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| **Head of Household (HOH) Information** | | | | | | | | | | | | | |
| **Head of Household Name** | | | **MAACLink Account #** | | | | | | **Age** | | | **Gender**  Female  Male | **Marital Status** |
| **Address** | **Apt.** | **City** | | | **Zip Code** | | **Phone** | | | | | **County**  Orange  Osceola  Seminole | **MM/YY of Residence** |
| **Family Type**  Single  Single Parent/Male  Two Parent Household  Two Adult/No Child  Single Parent/Female  Other | | **Ethnicity**  Hispanic/Latino  Non-Hispanic/Latino | | | | **Race** | | **Education Level** | | | | **Veteran**  Yes  No | **Disability**  Yes  No |
| **Employer** (Company Name) | | | | **Occupation** | | | | | | | **Net Monthly Pay** (after taxes)  $ | | |
| **Employer’s Address** | | | | | | | | | | **Employer’s Phone #** | | | |

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| **Household Housing Information** | | | |
| **Prior Residence** *(Where did you stay last night?)*  Room, apartment, or house that you rent, with NO subsidy  Emergency shelter, including hotel or motel with voucher  Room, apartment, or house that you rent, with subsidy  Hotel or motel paid without voucher  Apartment or house that you own, with NO subsidy  Transitional housing for homeless persons  Apartment or house that you own, with subsidy  Permanent housing for formerly homeless | | Staying in family member’s apartment/house  Psychiatric hospital or other psychiatric facility  Staying in friend’s room/apartment/house  Substance abuse treatment facility or detox center  Foster care home or group home  Hospital (non-psychiatric)  Jail, prison, or juvenile detention facility  Other  Place not meant for habitation (car, abandoned building, outside, etc.) | |
| **Length of Stay**  One week or less  More than one week, but less than one month  One to three months  More than three months, but less than one year  One year or longer | **Housing Status**  Literally homeless  Imminently losing housing  Unstably housed and at-risk of losing housing  Stably housed | | **Prior Zip Code**  *(Last stable residence of at least 90 days)* |

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| **Other Adult in Household Information** | | | | | | | | |
| **Other Adult Name** | | | | **Age** | | | **Gender**  Female  Male | **Marital Status** |
| **Relationship to HOH** | **Ethnicity**  Hispanic/Latino  Non-Hispanic/Latino | **Race** | **Education Level** | | | | **Veteran**  Yes  No | **Disability**  Yes  No |
| **Other Adult’s Employer** (Company Name) | | | **Occupation** | | | **Net Monthly Pay** (after taxes)  $ | | |
| **Employer’s Address** | | | | | **Employer’s Phone #** | | | |

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| **Additional Household Members** | | | | | | | | |
| **Name(s)** | | | | **Age** | | **Relationship to HOH** | | **Education Level** |
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| **Monthly Income** | | **Non-Cash Benefits** | | | **Expenses** | | | |
| Earned Income | $ | Food Stamps | $ | | Bus Pass | | $ | |
| Unemployment | $ | Medicaid |  | | Car Payment | | $ | |
| Social Security (SSI) | $ | Medicare |  | | Child Care | | $ | |
| Social Security Disability (SSDI) | $ | Healthy Kids |  | | Child Support Expense | | $ | |
| VA Disability | $ | WIC |  | | Electricity | | $ | |
| Private Disability | $ | VA Medical |  | | Food | | $ | |
| Worker’s Compensation | $ | TANF Child Care |  | | Gas/Heating | | $ | |
| Public Assistance (TANF) | $ | TANF Transportation |  | | Gas (Car) | | $ | |
| Veteran’s Pension | $ | Section 8 |  | | Car/Home Insurance | | $ | |
| Pension | $ | Other: | $ | | Medical | | $ | |
| Child Support | $ | Miscellaneous | | $ | |
| Alimony | $ |  |  | | Mortgage | | $ | |
| Other: | $ |  |  | | Rent | | $ | |
|  |  | | Sewage/Trash | | $ | |
| Other: | $ |  |  | | Telephone | | $ | |
|  |  | | Water | | $ | |
|  |  |  |  | | Other: | | $ | |
|  |  |  |  | | Other: | | $ | |
|  |  |  |  | | Other: | | $ | |
| **Total Income** | **$** | **Total Benefits** | **$** | | **Total Expense** | | **$** | |

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| **State specific need:** | Rent/Mortgage Assistance  Utility Assistance  Other:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **State why income is not available to pay monthly expenses:** | |
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| **Applicant Certification/Release of Information** | |
| I certify that all information I have provided above is true and correct. I consent to the release of information contained in this request to Heart of Florida United Way, other local social service agencies, and/or funders who distribute emergency financial assistance, and/or to the vendor receiving these funds, as necessary to complete services to my household, provide statistics on emergency assistance and as a guard against duplication of assistance. I also certify that if I or anyone in my household has been given emergency financial assistance in the past, I have advised the caseworker in this agency of that information. | |
| **I have read the Applicant Certification/Release of Information statement and understand it.**  **Signature:** | **Date:** |

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| **OFFICE USE ONLY** |

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| **Authorized Agency:** |  |

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| **Caseworker Name** |  | **Caseworker Phone #** |  |

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| **Fund** |  | **Service** |  |
| **Amount** | **$** | **Reason** |  |

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| **Vendor** |  | **Account #:** |  |
| **Payee** |  | | **Mail Check to Payee:** |
| **Address** |  | | |

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| **Authorized Signature** |  | **Date:** |  |