OKALOOSA COUNTY

SHIP Housing Program

APPLICATION FOR HOUSING ASSISTANCE

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| **Type of Assistance Requesting: Rehabilitation Assistance  Down Payment Assistance  Emergency Repair** | | |
| **For Rehab work please list Items the program should look at:** | | |
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| **Applicant *(Head of Household)*** | | |
| Full Name: | | |
| E-mail: | | |
| Date of Birth / Age: | | |
| Street Address: | | |
| City, State, Zip: | | |
| Home Phone: Cell Phone: Work Phone: | | |
| **Co-Applicant** | | |
| Full Name: | | |
| E-mail: | | |
| Date of Birth / Age: | | |
| Home Phone: Cell Phone: Work Phone: | | |
| **Other Household Members** | | |
| **Name(s)** | **Date of Birth / Age** | **Relationship to Applicant** |
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| **Is Applicant, Co Applicant or any other household member, age 18 or older, a full time student?** | | |
| **Yes  No  If yes Please list name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Does Applicant /Co-Applicant or any other household member, age 18 or older, own a home?** | | |
| **Yes  No  If yes Monthly rent/mortgage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Employment Information** | | |
| Employee Name: | | |
| Employer Name: Supervisor: | | |
| Address: | | |
| Phone: | | |
| Pay Rate: Hours per paycheck: Pay Frequency *(weekly, biweekly, monthly):* | | |
| Annual Income (gross salary, overtime, tip, bonuses, etc.): $ | | |
| Employer verification phone number/email: | | |
| **Employment Information** | | |
| Employee Name: | | |
| Employer Name: Supervisor: | | |
| Address: | | |
| Phone: | | |
| Pay Rate: Hours per paycheck: Pay Frequency *(weekly, biweekly, monthly):* | | |
| Annual Income (gross salary, overtime, tip, bonuses, etc.): $ | | |
| Employer verification phone number/email: | | |
| **Employment Information** | | |
| Employee Name: | | |
| Employer Name: Supervisor: | | |
| Address: | | |
| Phone: | | |
| Pay Rate: Hours per paycheck: Pay Frequency *(weekly, biweekly, monthly):* | | |
| Annual Income (gross salary, overtime, tip, bonuses, etc.): $ | | |
| Employer verification phone number/email: | | |
| ***\*\*\*Note: Attach additional sheets for employment as necessary for all household members 18 years and over\*\*\**** | | |
| **Other Sources of Income** (For ALL Household Members including minors. List Business, or Rental Income, Child Support, Alimony, Social Security, SSI, Pensions, Unemployment, Workers Comp., Welfare Payments, Veteran’s benefits, disability, regular payments from anyone outside household, etc.) Do NOT include; food stamps, student financial assistance, hostile fire military pay) | | |
| **Name** | **Type of Income** | **Gross Annual Amount** |
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| **Assets and Asset income** (For **ALL** Household Members, Including Minors. **List** Checking and Savings Accounts, Mobile Financial/Investment Apps, IRA, CD, Bonds, Stocks, Equity in Properties, Investment property (artworks, coins, stamp collections) cash on hand, etc.) Do NOT include personal property such as furniture, cars, and wedding rings. | | |
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| **Type of Asset** | **Asset Value / Annual Asset Income** | **Account Number** |
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| **Are you or any other Adult member of the household claiming zero income?** **Yes  No**  **If so name of household member(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  *Zero Income Declaration required for each person claiming zero income****.*** | | |
| **Do you or any other Adult member of the household expect any change in income Yes  No**  **in the next 12 months? If Yes, explain expected change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Ethnicity/Special Needs (For Reporting Purposes Only) Please check all that apply for Head of Household Only:** | | |
| White Black Hispanic Asian Native American Other | | |
| Farmworker  Developmentally Disabled  Elderly  Homeless  Special Needs  (Define) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other (Define) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| I/we understand that Florida Statute 817 provides that willful false statements or misrepresentation concerning income, asset or liability information relating to financial condition is a misdemeanor of the first degree, punishable by fines and imprisonment provided under Statutes 775.082 or 775.083. I/we further understand that any willful misstatement of information will be grounds for disqualification. I/we certify that the application information provided is true and complete to the best of my/our knowledge. I/we consent to the disclosure of information for the purpose of income verification related to making a determination of my/our eligibility for program assistance. I/we agree to provide any documentation needed to assist in determining eligibility and are aware that all information and documents provided are a matter of public record. | | |
| **Applicant Signature Date** | | |
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| **Co-Applicant Signature Date** | | |
|  | | |
| **Household Member Signature** *(over 18)* **Date** | | |
|  | | |
| **Household Member Signature** *(over 18)* **Date** | | |
|  | | |
| **Office Staff Confirmation**  ***Received Application (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  ***Received all documentation (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | | |
| *Print Signature Date* | | |