



Financial Assistance Application

**Orange County residents may apply for rent and/or utility assistance.
Seminole County residents may apply for utility assistance only.**

Thank you for reaching out to the *Christian Service Center for Central Florida* with your request for rent and/or utility assistance. Please read the following qualifications carefully and fill out all the information completely and accurately. A Case Manager will review your application once all required documentation is provided. Due to the large volume of requests for assistance, **please allow up to 10 business days to receive a response.**

Step 1 - Qualifications

Rental Assistance Qualifications

- You are an Orange County resident.
- Your household has income.
- Your monthly expenses are lower than your total monthly income.
- You do not owe more than one month's rent.
- You have documentation of an unexpected expense or loss of income within the last 45 days.
- You do not have an eviction case already filed in the court system.
- You have not received financial assistance from an agency in the last 12 months.
- Your landlord is willing to accept payment from an outside agency.

Utility Assistance Qualifications

- You are an Orange County or Seminole County resident.
 - You have documentation of an unexpected expense or loss of income within the last 45 days.
 - You have not received financial assistance from an agency in the last 12 months.
 - You do not have an eviction case already filed in the court system.
- **Also Note****
- We can only assist with current monthly charges.
 - We cannot pay towards a payment plan.

Please understand that providing the requested documentation does not guarantee approval for assistance. If you are approved, you may be eligible for up to \$1,000 in rental assistance and/or up to \$650 in utility assistance. If you owe more than this amount, you must be able to pay the remaining balance. Financial Assistance can only be provided once every 12 months.

The Christian Service Center can only review a limited number of applications per month. Once we reach the maximum number of requests, we will temporarily stop accepting new applications until the following month.

If you meet all the qualifications listed above, please proceed to Step 2

Step 2 - Documentation

List of Required Documents
<ul style="list-style-type: none"><input type="checkbox"/> Completed application (Pages 3-5)<input type="checkbox"/> Signed and dated "Release of Information" (Page 6)<input type="checkbox"/> Completed "Monthly Budget Worksheet" (Page 7)<input type="checkbox"/> Unexpected expense and/or loss of income within the last 45 days<ul style="list-style-type: none">• Some examples may include receipts for medical bills, car repair, verification of job loss, temporary reduction of hours, or short-term unpaid medical leave<input type="checkbox"/> Full and complete lease<ul style="list-style-type: none">• Signed by tenant and landlord.• Current lease, cannot be expired<input type="checkbox"/> Three-day eviction notice * If applicable*<input type="checkbox"/> Income verification for all adults in the household<ul style="list-style-type: none">• Last four weeks of paystubs• Letter of hire on company letterhead that includes:<ul style="list-style-type: none">○ Rate of pay.○ Number of hours per week○ Start date.○ Employer contact information• Child support/alimony• SSI/SSDI• Unemployment• Veteran's benefits• SNAP benefits.• TANF – Cash Assistance<input type="checkbox"/> Bank statements for the current and previous month for all adults in the household<input type="checkbox"/> Utility bill for the current month<input type="checkbox"/> Driver's license or state ID for all adults in household

If you can provide all of the required documentation listed above, please proceed to Step 3

Step 3 - Application

Client Intake Form - *Please Print Clearly*****

First, Middle & Last Name:	
Phone Number:	Social Security Number:
Date of Birth:	Email Address:
Street Address:	
Apartment #:	
City, State, Zip Code:	

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary/Non-Conforming <input type="checkbox"/> Prefer not to answer
Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when are you due? _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Race: <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other _____
Ethnicity: <input type="checkbox"/> Hispanic/Latin(a)(o)(x) <input type="checkbox"/> Non-Hispanic/Latin(a)(o)(x)

Are you a U.S Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of disability? <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Developmental <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other _____	
Are you covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of insurance? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> Other _____	

Do you receive any income for your household?
 Yes No

If yes, what type of income?
 Alimony Child Support Employment SSI SSDI TANF VA Benefits
 Other _____

What is the average monthly income for your household?
 \$ _____

Do you receive SNAP (Supplemental Nutrition Assistance Program) benefits for your household?
 Yes No

How much do you receive per month?
 \$ _____

Have you ever experienced domestic violence?
 Yes No

If yes, when?
 Within the past 3 months 3-6 months ago 6-12 months ago More than 1 year ago

Please include information for all other members of your household:

Name	Relationship to You	Date of Birth	Gender
Social Security Number	Race	Ethnicity	Health Insurance?
		Hispanic / Non-Hispanic	Yes / No
Name	Relationship to You	Date of Birth	Gender
Social Security Number	Race	Ethnicity	Health Insurance?
		Hispanic / Non-Hispanic	Yes / No
Name	Relationship to You	Date of Birth	Gender
Social Security Number	Race	Ethnicity	Health Insurance?
		Hispanic / Non-Hispanic	Yes / No
Name	Relationship to You	Date of Birth	Gender
Social Security Number	Race	Ethnicity	Health Insurance?
		Hispanic / Non-Hispanic	Yes / No

Describe the unexpected expense and/or loss of income that occurred within the last 45 days:

I am requesting assistance with:

<input type="checkbox"/> Rent	I currently owe \$ _____
<input type="checkbox"/> Utilities	I currently owe \$ _____

If requesting Rental Assistance, provide the following information:

Name of Apartment Complex	
Name of Landlord/Property Manager	
Street Address	
City, State, Zip Code	
Phone Number	
Email Address	

Release of Information



*Homeless Services Network of Central Florida
HMIS Department | Official Document*

*Continuum of Care FL-507 | Homeless Services Network of Central Florida
Client Informed Consent & Authorization for Release of Information in HMIS*

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions or desire any further information regarding this form, please contact the system administrator via the HSN HMIS Help Desk by phone (407-893-0133 x640) or by submitting a ticket on our website (<https://hmiscfl.org>).

1. In order to best serve your needs at Christian Service Center for Central Florida, to develop meaningful treatment plans, to determine your continuing eligibility for services, and to monitor your progress in complying with the terms of your shelter, housing or other services, Christian Service Center for Central Florida and the Continuum of Care need to exchange, share, and/or release data, information or records they may collect about you.

2. The information contained in your case records with any Agency is considered confidential and privileged and cannot be exchanged, shared and/or released without your express and informed written consent, except where otherwise authorized by law. Please understand that access to shelter, housing and services is available without your consent for the release of the information. However, your consent to share information with other service agencies is a critical component of our community's ability to provide the most effective services and housing possible.

3. I understand that:
 - a) This Agency may not refuse to serve me simply because I do not want my information shared with other service agencies.
 - b) This form specifically authorizes the use of information about me in research conducted using information maintained in the HSN HMIS. I will not be personally identified by name, social security number, or any other unique characteristic in published research reports. The type of research that will be conducted using this information includes reports on the number and characteristics of people using different types of services, the effectiveness of services, and changes in patterns over time.
 - c) If I give permission, the HSN HMIS will allow information about me, including records previously entered into the HSN HMIS, to be shared among HSN HMIS Partner Agencies. This may include, but is not limited to, my photograph, information regarding my education history and employment background, income, program eligibility and participation, and personal history. The purpose of sharing information is to help the agencies from which I seek services to obtain information about me faster, to assist with my case management, and to connect me more quickly with the services I need.
 - d) Agencies that join the HSN HMIS after I sign this consent/authorization also will have access to the personal information that I authorize for data sharing. This Agency must make reasonable accommodations to allow me to view the updated list of HSN HMIS Partner Agencies.
 - e) I understand that I have the right to inspect, copy, and request all records maintained by an Agency relating to the provision of services provided by an Agency to me and to receive a copy of this form unless specifically denied under federal or state law. I understand that my records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise authorized by law. I understand that this release is valid for three years from the date I sign this document. I may revoke this authorization at any time verbally or by written request, but the cancellation will not be retroactive.

I give my consent to the exchange of information via the HSN HMIS: Yes No

I have read this document or it was read and/or explained to me and I fully understand and agree with the terms of this document.

Name and Signature of Client _____ <small>(Print)</small>	Name and Signature of Witness Christian Service Center _____ <small>(Print)</small>
_____ <small>(Signature)</small>	Christian Service Center 2023 _____ <small>(Signature)</small>
_____ <small>(Date)</small>	_____ <small>(Date)</small>

Monthly Budget Worksheet					
Earned Income	\$	Food Stamps (SNAP)	\$	Bus Pass	\$
Unemployment	\$	Medicaid	<input type="checkbox"/>	Car Payment	\$
Social Security (SSI)	\$	Medicare	<input type="checkbox"/>	Child Care	\$
SSDI	\$	Healthy Kids	<input type="checkbox"/>	Child Support Expense	\$
VA Disability	\$	WIC	<input type="checkbox"/>	Electricity	\$
Private Disability	\$	VA Medical	<input type="checkbox"/>	Food	\$
Worker's Comp	\$	TANF Child Care	<input type="checkbox"/>	Gas/Heating	\$
TANF	\$	TANF Transportation	<input type="checkbox"/>	Gas (Car)	\$
Veteran's Pension	\$	Section 8	<input type="checkbox"/>	Car/Home Insurance	\$
Pension	\$	Other:	\$	Medical	\$
Child Support	\$			Miscellaneous	\$
Alimony	\$			Mortgage	\$
Other:	\$			Rent	\$
Other:	\$			Sewage/Trash	\$
				Telephone	\$
				Water	\$
				Other:	\$
Total Income	\$	Total Benefits	\$	Total Expenses	\$

By signing below, I agree that the information I have provided in this application is complete and accurate to the best of my knowledge. I understand that providing false information on this application will disqualify me from receiving assistance. I understand that completing this application does not guarantee approval for assistance.

Print Name _____ Date _____

Signature _____

Step 4 - Submittal

Your completed application and all required documents should be included in one email and sent to FinancialAssistance@ChristianServiceCenter.org. Your completed application and copies of documents can also be dropped off in person at one of our 3 locations listed below.

Downtown Orlando	West Orange	Winter Park
808 W. Central Blvd. Orlando, FL 32805 Mon - Thurs 9:00 am-4:00 pm Fridays 9:00 am-12:00 pm	300 West Franklin Street Ocoee, FL 34761 Mon - Fri 9:00 am-1:00 pm	3377 Aloma Avenue Winter Park, FL 32792 Mon - Fri 9:00 am-1:00 pm