Financial Assistance Application for Rent and/or Utilities
(Orange County Residents Only)

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

Documentation Required:

- ☐ Current lease signed by tenant and landlord
- ☐ Last four weeks of Paystubs
- ☐ Documentation of any additional income sources (e.g., Child Support, SSI/SSDI, Unemployment, Veteran's benefits)
- ☐ Driver's License or State ID for all adults in household
- ☐ Social Security card for everyone in household
- ☐ Birth certificate for all minors in household
- ☐ Last two months of bank statements
- ☐ Current and last month's utility bill
- ☐ Documentation of unexpected events/expenses within the last 45 days (e.g., medical bill, car repair, lost wages, funeral expenses)
- ☐ SNAP benefits award letter (If applicable)
- ☐ Three-day eviction notice (If applicable)
- ☐ If beginning a new job, provide a "Letter of Hire" from your employer that includes rate of pay, number of hours per week and start date. Needs to be on company letterhead.

Please note, we are unable to assist individuals with the following situations:

- You do not have any income for your household
- You are already in the process of being evicted through the court system
- Your monthly expenses are more than your monthly income
- You have already received financial assistance from an agency in the last 12 months
- You need help with your OUC bill (we can only assist with Duke Energy at this time)

*****Your completed application and all documents should be included in one email and sent to FinancialAssistance@christianservicecenter.org. Your 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 West Central Blvd Orlando, FL 32805 9:00am-4:00pm	300 West Franklin Street Ocoee, FL 34761 9:00am-1:00pm	3377 Aloma Avenue Winter Park, FL 32792 9:00am-1:00pm

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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:
☐ Male ☐ Female ☐ Transgender ☐ Non-Binary/Non-Conforming ☐ Prefer not to answer

Are you currently pregnant?
☐ Yes ☐ No
If yes, when are you due? ___________________

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race:
☐ American Indian, Alaska Native, or Indigenous ☐ Asian ☐ Black/African American
☐ Native Hawaiian or Pacific Islander ☐ White/Caucasian ☐ Other ______________________

Ethnicity:
☐ Hispanic/Latin(a)(o)(x) ☐ Non-Hispanic/Latin(a)(o)(x)

Are you a U.S Citizen? ☐ Yes ☐ No	**Are you a veteran?** ☐ Yes ☐ No

Are you a disabled?
☐ Yes ☐ No
If yes, what type of disability?
☐ Alcohol Abuse ☐ Chronic Health Condition ☐ Developmental ☐ HIV/AIDS
☐ Mental Health ☐ Physical ☐ Substance Abuse ☐ Other ____________________

Are you covered by health insurance?
☐ Yes ☐ No
If yes, what type of insurance?
☐ Medicaid ☐ Medicare ☐ VA Medical Services ☐ Employer-Provided Health Insurance
☐ COBRA ☐ Private Pay Health Insurance ☐ Other ____________________

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

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Please describe your situation, including the reason that you were unable to meet your expenses this month:

I am requesting assistance with:	
☐ Rent	I currently owe $____________
☐ Duke Energy	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	

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.

Print Name ____ Date ____________

Signature ____

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Monthly Budget Worksheet

Cash Income Sources

Income Sources	Amount	Frequency	Monthly Income
Job/ Earned Income	$		$
Child Support	$		$
TANF	$		$
SSI	$		$
SSDI	$		$
Inheritance	$		$
Other:	$		$
Other:	$		$
Total Income	**$**		**$**

Non-Cash Income Sources

Income Sources	Amount	Frequency	Monthly Income
Food Stamps	$		$
Other	$		$
Other	$		$
Total	**$**		**$**

BUDGET ANALYSIS:

Total Monthly Cash Income	$
Total Monthly Expenses	$
Monthly Variance (Total Income minus Total Expenses)	**$**

Expenses

Expenses	Amount	Frequency	Monthly Expenses
Rent	$		$
Rent Arrears (Back Rent)	$		$
Child Care	$		$
Utilities	$		$
Utilities Arrears (Back Pay)	$		$
Clothing	$		$
Groceries	$		$
Car Payment	$		$
Car Insurance	$		$
Car Maintenance & Fees	$		$
Gasoline	$		$
Public Transportation	$		$
Medical/Prescriptions	$		$
Dental	$		$
Vision	$		$
Telephone - Landline	$		$
Telephone - Cell	$		$
Cable/Internet	$		$
Other:	$		$
Other:	$		$
Total	**$**		**$**

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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	**Name and Signature of Witness**
(Print)	(Print)
(Signature) (Date)	(Signature) (Date)