PLEASE NOTE:

WHEN RETURNING THIS FORM, PLEASE MAKE SURE YOU DATE AND SIGN WHERE INDICATED.

ALSO PROVIDE COPIES OF THE FOLLOWING HOUSEHOLD DOCUMENTS:

1. PHOTO IDENTIFICATION
2. SOCIAL SECURITY CARDS FOR ALL MEMBERS OF THE HOUSEHOLD
3. BIRTH CERTIFICATES FOR ALL MEMBERS OF THE HOUSEHOLD
4. ***RECENT TO DATE LETTER FROM SOCIAL SECURITY OR DISABILITY (IF APPLICABLE)**
5. **6 MONTHS CONSECUTIVE BANK STATEMENTS (all pages of bank statements please)**
6. **6 MONTHS CONSECUTIVE WAGE STATEMENTS (IF APPLICABLE)**
7. **RECEIPT OF CURRENT PAID TAXES ON PROPERTY**

IF THE ABOVE INFORMATION IS NOT PROVIDED, IT WILL DELAY PROCESSING OF YOUR APPLICATION.

YOU MAY BRING YOUR APPLICATION TO OUR OFFICE LOCATED AT: 323 N SINCLAIR AVENUE, TAVARES

OR MAIL TO: **LAKE COUNTY HOUSING**
P O BOX 7800,
TAVARES, FL 32778-7800

IF YOU HAVE ANY QUESTIONS, PLEASE CALL (352) 742-6540

Please select the appropriate category for which you are requesting assistance:

_____ Emergency Roof Repair _____Emergency Well Repair _____ Emergency Septic Tank Repair
_____ Emergency Drainfield Repair _____Mobility Ramp Installation

LAKE COUNTY
COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM
APPLICATION FOR ASSISTANCE

PLEASE PRINT

Applicant: _____ Date: _____

Social Security Number: _____ Phone: _____

Address: _____

City/State/Zip: _____

This information is required only for State record keeping per Florida Statute 420.9075 (9) (a). Lake County fully supports equal opportunity housing and does not discriminate on the basis of race, national origin, religion, sex, age, family size, or handicap. Ethnicity, please indicate the number in household for each race:
White/Caucasian _____ Black/African American _____ Latino/Hispanic _____ Asian/Pacific Islander _____ Native American/Indian _____ Other (specify) _____

The Head of Household: _____Female _____Male

List name of all household member(s), birth dates, and relationship to applicant. Attach a copy of the social security card for each household member.

NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT

Part A: Income Assessment

Do you receive child support for the above named children? _____Yes _____No _____N/A
Has child support been court ordered? _____Yes _____No

Applicant Employment Information:

Employee Name:		**Employer Name:**	
Position:		**Supervisor:**	
Address:		**Phone:**	
Hire Date:	**Pay Rate:**	**Pay Frequency:**	**Seasonal? Y N**
Annual Income (gross salary, overtime, tips, bonuses, etc.): $			

Co-Applicant Employment Information:

Employee Name:		**Employer Name:**	
Position:		**Supervisor:**	
Address:		**Phone:**	
Hire Date:	**Pay Rate:**	**Pay Frequency:**	**Seasonal? Y N**
Annual Income (gross salary, overtime, tips, bonuses, etc.): $			

Income for all other household members from all other sources (including unemployment compensation, child support awards, pension, public assistance):

Source of Income	Amount	Time Period
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This year's estimated gross annual earnings (for all household members 18 years and older: $_____

Is any household member 18 years or older and a full-time student? _____

If yes, please list: _____

Part B: Assets and Asset Income- List all checking and saving accounts, IRA, CD, bonds, stocks, and equity in properties, etc.) **List assets for ALL household members, including minors.**

	Account Number (s)	Cash Value	Asset	None
Checking Account	_____	_____	_____	_____
Savings Account	_____	_____	_____	_____
401K/TSA	_____	_____	_____	_____
Retirement/Annuity	_____	_____	_____	_____
Certificate Of Deposit	_____	_____	_____	_____
Stocks: (market value)	_____	_____	_____	_____
Bonds: (market value)	_____	_____	_____	_____
Property (market value)	_____	_____	_____	_____
Other	_____	_____	_____	_____

Describe any other assets such as real property, machinery or equipment or any items of value not excluded in the definition of net assets. Provide an estimated value for each item listed. (Attach additional pages if necessary)

_____
_____
_____
_____

Part C: Insurance (only applies to prescription assistance)

Check all that apply: ____ Medicaid ____ Prescription Insurance ____ Prescription Discount Card

Part D: Certification

I/We, the Applicant(s), understand that Florida Statute 817.03 provides that willful false statements or misrepresentation concerning income or asset 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 either termination of the application process or, if awarded funding assistance, the total amount of the funding assistance originating from the Lake County Community Development Block Grant Program (CDBG funds) shall become immediately due and payable by the Applicant(s). **I/we certify that the application information provided in this application is true and complete as of the date set forth beside my/our signature on this application. 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 Date Signed

_____ _____

Co-Applicant Date Signed

LAKE COUNTY
FLORIDA

COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG)

NOTIFICATION

COLLECTION OF SOCIAL SECURITY NUMBERS

PLEASE NOTE: The Lake County Department of Community Services collects social security numbers for the following purposes: classification of accounts; identification and verification; credit worthiness; billing and payments; data collection; reconciliation; tracking; benefit processing; and tax reporting. Social security numbers are also used as a unique numeric identifier and may be used for search purposes.

Acknowledgement of notification:

_____ _____

Head of Household Signature Date

_____ _____

Spouse/Other Adult Signature Date