



COMMUNITY SERVICES DEPARTMENT
 COMMUNITY ASSISTANCE DIVISION
**Community Services Block Grant (CSBG)
 Family Self Sufficiency Program (FSSP)**

Seminole County Community Assistance Division is now accepting applications for the CSBG Family Self Sufficiency Program. Applications will be accepted Monday, February 8, 2016-Friday, March 4, 2016 at the Reflections Plaza located at 534 W. Lake Mary Blvd. Sanford, FL 32773.

Please Note: A limited number of slots are currently available. Applications will be reviewed based on the date/time stamped; first completed basis; and based on eligibility. Eligible applicants who are not approved for assistance will be placed on a waiting list. Please read the eligibility requirements below carefully before applying.

To apply for this program your household must meet all of the requirements listed below:

CSBG FSSP HOUSEHOLD REQUIREMENTS:

- A. Current Seminole County Resident
- B. Head of Household or co head must not own any type of property
- C. Household income must be at or below 125% of the Federal Poverty Levels listed below
- D. Head of Household must work at least 32 hours per week
- E. Participant must possess a high school diploma or GED at the time of application
- F. Participant cannot have completed a bachelor's degree or higher education
- G. Household must have the potential to increase income
- H. Head of household must be willing to enroll in a vocational/Technical training program
- I. *Preference will be given to those interested in entering the following fields: Medical, Information Technology (I.T.), or Construction/Tradesman*

REQUIRED DOCUMENTS TO SUBMIT WITH APPLICATION:

- A. Valid Florida ID of all adult household members
- B. Social Security Cards and Birth Certificates of all household members
- C. Documentation of all household income for the last 3 months (includes earnings, social security, veteran benefits, pensions, retirement, child support, cash assistance, food stamps)
- D. Valid Lease Agreement in head of household or co head's name
 - i. If homeless, documentation of homelessness in Seminole County
- E. Current utility bill (water, electric, or gas) within the last 30 days in head of household or co head's name

***Application submitted without the documents noted above will not be reviewed.**

125% OF FEDERAL POVERTY LEVEL

1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
\$14,713	\$19,913	\$25,113	\$30,313	\$35,513	\$40,713	\$45,913	\$51,113

***Households do not qualify if they own a home, live in subsidized housing; receive Section 8, other Tenant Base Rental Assistance (TBRA), have received assistance from other County assisted housing programs such as HPRP, CSBG FSSP, in the last 5 years; or are currently receiving any other Federally funded rental assistance.**

County reserves the right to stop accepting applications at any time.

Seminole County Community Services Department
Community Assistance Division

534 W. Lake Mary Blvd. • Sanford, FL 32773 • Phone (407) 665-2300 • www.seminolecountyfl.gov/comsrvs/



SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

**SEMINOLE COUNTY COMMUNITY ASSISTANCE
APPLICATION FOR ASSISTANCE**

All sections of the application **must** be completed; if a section does not apply to your household, enter "N/A."

PLEASE CHECK ASSISTANCE APPLYING FOR

Self Sufficiency

(Please Print Clearly)

Applicant		Co-Applicant (Spouse or member 18 & older)
Full Name:		
Age & Date of Birth:		
Social Security #:		
Gender: Circle One	Male or Female	Male or Female
Relationship of Co-Applicant to Applicant:		<input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Roommate <input type="checkbox"/> Relative <input type="checkbox"/> Non-relative
Ethnicity/Special Needs: (For reporting purposes only, please check all that apply for Head of the Household Only)		
White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>		
Farm Worker <input type="checkbox"/> Disabled <input type="checkbox"/> or Disabled Minor <input type="checkbox"/> Elderly <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____		
Applicant Street & Mailing Address:		
Street Address:		Rent <input type="checkbox"/> State:
City:		City Limit <input type="checkbox"/> Unincorporated <input type="checkbox"/> Zip:
Mailing Address (if different):		State:
City:		Zip:

Telephone Number: _____ E-mail Address: _____

Emergency Contact Name: _____ Emergency Phone Number: _____

Marital Status: Married Separated Single Divorced Widowed

OTHER MEMBERS IN THE HOUSEHOLD

Name	Date of Birth	Age	Relationship to Applicant	Social Security Number

*If additional space to list household members is needed please attach information to the back of this application.

Applicant Employment Information:

Current/Last Employer Name:		Phone Number:	
Address:			
Supervisor:		Fax Number:	
Position:	Start Date:	End Date:	

Co-Applicant Employment Information:

Current/Last Employer Name:		Phone Number:	
Address:			
Supervisor:		Fax Number:	
Position:	Start Date:	End Date:	

*If additional space to list employment information is needed please attach information to the back of this application.

INCOME RECEIVED MONTHLY

List the amount of income received monthly in column two by the source of income listed in column one. If income is listed in column one then the documents listed in column three are required if applicable. Column three lists the required documents of the various income sources listed in column one. **Forms**, in bold, are available in the Community Assistance Office or online with the application. The Community Assistance Office can notarize required documents below.

Column One	Column Two	Column Three
		Client will also have the option to use 3rd Party Verification if source is not available or more information is required to clarify income and assets. The client is responsible for any costs associated with the completion of 3rd Party Verifications .
Employment	\$	Provide Pay Stubs. All adults (18 years of age or older) in the household who are currently claiming no income, must sign and notarize a Verification of No Monthly Income form
AFDC/TANF/ (Cash Assistance)	\$	AFDC/TANF (Aid to Families with Dependent Children/Temporary Assistance for Needy Families) Printout or current decision letter from the Department of Children and Families. Provide Decision Notice or Printout
Social Security, SSI, SSDI, Pensions (VA, Military, Retirement)	\$	Provide a copy of current year Award or Benefit Statement. <i>A statement is required for <u>each</u> household member receiving benefits. (Provide current year award letters)</i>
Unemployment Compensation	\$	All adults (18 years of age or older) in the household who are currently receiving unemployment, must sign and have notarized a DEO/AWI (form).
Alimony/ Child Support	\$	Divorce Decree or Court Order and child support and/or <i>alimony payment schedule if applicable, (must show Child Support); or Provide a notarized letter from the person paying support; <i>only if the support is not court ordered;</i> or Provide a printout from the court or government agency through which payments are being made. (Last 6 months print out is required for deposits and dental programs).</i>
FOOD STAMP ASSISTANCE	\$	Monthly food stamp assistance from the State of Florida for single adults and families.
Business or Rental Net Income	\$	Provide a copy of profit and loss statement; <u>and</u> provide the business bank statements.
Workmen's Compensation	\$	Provide documentation from employer of amount and frequency of workmen's compensation.
Short- or Long- Term Disability	\$	Provide documentation from employer of amount and frequency of disability compensation.
Recurring Contributions and Gifts	\$	Provide a letter stating the amount and frequency of payment from the bank, attorney, or a trustee providing required verification; <u>or</u> A Verification of Recurring Cash Contributions (form) must be completed by the payee.
Other	\$	Please provide documents of all other source of income in the household.

EXPENSES PAID MONTHLY

Childcare or Child Support Payments	\$	Car Insurance	\$
All Loan(s) other than Car, Real Estate, Mortgage and Student Loans	\$	Medical	\$
Rent, Real Estate & Mortgage Loans	\$	Food	\$
Electric & Water & Gas	\$	Gas (Automobile)	\$
Phone – (Including Cell Phone & Cable)	\$	All Credit Cards	\$
Car Payment(s)	\$	Student Loan(s) Other	\$

ASSETS AND ASSET INCOME

For ALL Household Members, Including Minors, List Checking and Savings Accounts, IRA, CD, Bonds, Stocks, Equity in Properties, Whole Life Insurance, Pensions, etc. All adults (18 years of age or older) in the household who do not have a financial account, must sign a **Verification of No Financial Accounts** (form). **(Please provide the last 6 months of Bank Statements or benefit statements for Deposit and Dental cases only)**

Type of Asset	Financial Institution	Account #
1.		
2.		
3.		
4.		

*If additional space to list assets is needed please attach information to the back of this application.

ADDITIONAL QUESTIONS

Please read and answer all questions below, additional documents are required for questions with an asterisk *.

Forms, in bold, are available in the Community Assistance Office or online with the application.

*Are copies of valid Florida Photo ID or valid Florida Drivers License for all adult household members (18 years of age or older) attached to the application? Yes No

*Are copies of Social Security Cards **and** birth certificates for all household members attached to application? Yes No

*Are you an employee or related to an employee of Seminole County Government? If yes, please list the relationship: _____ Yes No

CITIZENSHIP/RESIDENCY:

Are you a U.S. citizen? Yes No

*If no, are you a permanent resident of the U.S.? (If yes, a copy of the resident card must be provided.) Yes No

LIVING ARRANGEMENTS:

*Is this a Section 8, Subsidized, TBRA or Public Housing Rental? Yes No

***Note: Rent and Utility assistance cannot be provided to customers who have Section 8, TBRA, Shelter Plus Care or are with a Housing Authority**

Are you homeless? Yes No

If yes, what are your current living arrangements? homeless shelter/facility other, please state: _____

HEALTH:

Do you have Dental Insurance or a discount plan/policy? Yes No

Do you have Vision Insurance or a discount plan/policy? Yes No

Do you have Medicaid Insurance? Yes No

Do you have Medicare Insurance? Yes No

EDUCATION:

Are you a high school graduate? Yes No

If yes, year of graduation: _____ If no, highest grade completed: _____

Please list any college degrees or vocational training you have completed: _____

Is Applicant, Co-Applicant, or any other household member 18 or older a full-time student? Yes No

*If yes, please list member(s) and provide supporting documentation if applying for Self-Sufficiency Program: _____

EMPLOYMENT:

Are you currently seeking employment? Yes No

If no, explain: _____

VETERAN:

Are you a Veteran or Spouse/Dependent of a Veteran?

Yes No

If yes to either question, may our Veteran Service Officer contact you?

Yes No

REASONABLE ACCOMODATIONS:

Hearing impaired: Do you need TTD/TDY access to our staff?

Yes No

Do you require accommodations for a disability?

Yes No

If yes, what accommodations do you need? _____

Please complete if applying for the Training Program only:

Institution Name:				Program Name:		
This Program will enable me to (circle one):	Attain Employment	Maintain Employment	Increase Income and/or Benefits			
Anticipated Enrollment Date:			Anticipated Graduation Date:			
Tuition Amount:	\$	Cost of Books:	\$	Cost of Training Supplies:	\$	

We collect personal information directly from you for reasons that are discussed in our privacy statement. We may be required to collect some personal information by law or by organizations that give us money to operate this program. Other personal information that we collect is important to run our programs, to improve services for homeless individuals, and to better understand the need of homeless individuals. We only collect information that we consider to be appropriate.

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 and 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. I/we further understand that if any misrepresentation or fraudulent statement is discovered after assistance has been provided, the County will demand and pursue through all legal remedies available, repayment of the funds provided for the assistance that was provided. The undersigned further understands that providing false representations herein constitutes an act of fraud. **Applicants that knowingly provide false, misleading or incomplete information will result in denial of application and barred from services from this office.**

***The Applicant and Co-Applicant must sign below.**

Applicant Signature

Date

Co-Applicant Signature

Date

Other Adult Member Sign Your Name

Other Adult Member Sign Your Name

THIS SECTION FOR OFFICIAL USE ONLY					
PROGRAM	<input type="checkbox"/> SHIP	<input type="checkbox"/> EHEAP	<input type="checkbox"/> ESGP	<input type="checkbox"/> SCU	<input type="checkbox"/> ADDI
	<input type="checkbox"/> BCC	<input type="checkbox"/> CDBG	<input type="checkbox"/> CSBG	<input type="checkbox"/> EFSP	<input type="checkbox"/> TBRA
Staff Signature:					
Supervisor Signature:					
Service Approved:					
Award Amount:					
Denied:					
Denial Reason:					

SEMINOLE COUNTY COMMUNITY ASSISTANCE AUTHORIZATION FOR THE RELEASE OF INFORMATION

Please print information, do not use white-out.

I _____, the undersigned, hereby authorize
_____ to release by third party, without liability, information

(Leave this line blank, agency to complete)

in regards to employment, income, residency, dependency, or claims of loss or other confidential information pertaining to me and/or assets to the Seminole County Community Assistance Office, for the purposes of verifying information provided as part of determining eligibility for assistance under this application for assistance. I understand that only information necessary for determining eligibility can be requested. **This authorization is valid up to one year from date signed.**

TYPES OF INFORMATION TO BE VERIFIED:

I/We understand that previous or current information regarding me/us may be required. Verifications that may be requested are, but not limited to: employment history, hours worked, salary and payment frequency, commissions, raises, bonuses, and tips; cash held in checking/savings accounts, stocks, bonds, Certificates of Deposit, Individual Retirement Accounts, interest, dividends; payments from Social Security/SSI, annuities, insurance policies, retirement funds, pensions, disability or death benefits, unemployment, disability or worker's compensation, welfare assistance, net income from the operation of a business, and alimony or child support payments.

Organizations/individuals who may be asked to provide written/oral verifications are, but not limited to:

Past and Present Employers	Welfare Agencies/Other Social Service	Veterans Administration
Past and Present Landlords <i>(including Public Housing Agencies-TBRA/Section 8)</i>	Agencies and Non Profit Agencies	Retirement Systems
Support and Alimony Providers	State Unemployment Agencies	Banks and other Financial Institutions
Hospitals/Doctors/Pharmacies/Clinics	Social Security Administration	Religious Organizations
Funeral Homes and Crematories	Utility Companies	

CONDITIONS:

I/We agree that a photocopy of this authorization may be used for the purposes stated above. I/We understand I/we have a right to review this file and correct any information found to be incorrect.

Applicant Sign Your Name _____ Print Your Name _____ Date _____

Co-Applicant Sign Your Name _____ Print Your Name _____ Date _____

Other Adult Member Sign Your Name _____ Print Your Name _____ Date _____

Other Adult Member Sign Your Name _____ Print Your Name _____ Date _____

Note: This general consent may not be used to request a copy of a tax return or medical records.



Assistance will be provided according to the program eligibility requirements and the availability of funding; some restrictions apply.

This program is open to all without regard to race, color, national origin, sex, handicap, familial status, or religion. All Seminole County programs are on a first come, first completed basis. Those who supply the Program with all the information needed to process their application while funds are available will be processed first.

HOURS OF OPERATION:

Our office is open Monday thru Friday from 8 a.m. – 5 p.m.

Seminole County Community Assistance/Housing & Financial Assistance - 534 West Lake Mary Blvd - Sanford, FL 32773 Ph: 407-665-2300 Fax: 407-665-2358

**CSBG Family Self-Sufficiency Program (FSSP)
Supplemental Screening Questionnaire**

1. What are your educational and employment goals?

2. Are there any barriers or limitation to the goals you describe above? If so, please describe?

3. Are you currently employed? Yes () No () If "Yes", where are you employed? Please give employer address and telephone number.

If "Yes", how long have you been employed? _____

What is the title of your current position? _____

If "No", how long have you been unemployed? _____

5. What is the last grade of school completed? _____

If you did not complete high school do you have a state approved GED?

Yes () No ()

6. Are you currently attending any training or educational programs?

Yes () No ()

If "Yes", what type? _____

Where? _____

If "No", are there any problems or reasons that would prevent you from enrolling in a training or educational program now? () Yes () No

If "Yes", please explain:

7. Do you hold any certificates or college degrees? Yes () No ()

If "Yes", what type? _____

8. Do you have any support system in place? () Yes () No

If yes, what Type? _____

Who will watch your children while you are in school or working?

9. Do you have transportation? () Yes () No

If no, how will you get back and forth to work/school? _____

If yes, what Type? _____

10. Please describe in your own words why you and your family would benefit from the Family Self-Sufficiency Program.
