CRF DISASTER ASSISTANCE PACKET

MORTGAGE ASSISTANCE

CONTENTS:

- Checklist
- Intake Application
- Self-Certification Form
- Duplication of Benefits Form

Checklist

I have enclosed the following documents to be returned to Suwannee River Economic Council, Inc.:

- [ ] Intake Application (include add'l Section 3 pages if required)
- [ ] Self-Certification Form
- [ ] Duplication of Benefits Form
- [ ] ID for all household members (Driver's License, Birth Certificate, Voter's Registration Card, or other ID.)
- [ ] Proof of ownership in applicant's name (Warranty Deed, Homestead Exemption, Quit Claim Deed, property tax card.)
- [ ] Copy of most recent monthly mortgage statement.

Return this form and all required documents to:

Mail: SREC, INC.
POB 70
LIVE OAK FL 32064
ATTN: CRF

OR

Email: crf@suwanneeec.net

Intake Application

1. Read completely

2. ***PLEASE PRINT***.

3. Each individual household member age 18 and over must complete Section 3, page 3. Additional pages are included if needed.

CRF DISASTER PROGRAM INTAKE APPLICATION

FOR OFFICE USE ONLY		
APP # _____	STAFF INITIALS _____	DATE REC'D _____

What type of housing assistance are you requesting?	[ ] Rent [ ] Mortgage
Other (Explain)	
SECTION 1. TO BE COMPLETED BY APPLICANT: (Head of Household)	
Full Name:	
Current Address:	**Apt#**
City, State Zip:	
Daytime phone:	**Mobile Phone:**
E-mail Address:	**Date of Birth:**
Marital Status:	**Age:**
Employed? Yes No	**Self Employed? Yes No**
TO BE COMPLETED BY CO-APPLICANT:	
Full Name:	
Daytime phone:	**Mobile Phone:**
E-mail Address:	**Date of Birth:**
Marital Status:	**Age:**
Employed? Yes No	**Self Employed? Yes No**

SECTION 2. HOUSEHOLD COMPOSITION, CHARACTERISTICS AND FAMILIAL STATUS: - As of today, all other members of the household. Indicate the relationship of each family member to the Head of Household (spouse, sibling, etc.). In addition, indicate if there are any additional members in the near future to the household.

Household Member Name	Relationship to Head of HH	Age	Date of Birth	Marital Status	Is household member listed disabled? Y/N	Employed
						Yes No
						Yes No
						Yes No
						Yes No
						Yes No
						Yes No
						Yes No
						Yes No

HEAD of HOUSEHOLD ONLY (Check one): -This information is being collected for reporting purposes only.

RACE (Check all that apply):

☐ American Indian or Alaska Native	☐ Asian
☐ Native Hawaiian or Other Pacific Islander	☐ White
☐ Black or African American	☐ Other Multi-Racial

ETHNICITY (Check one):

☐ Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

☐ Non-Hispanic or Latino - A person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

SECTION 3. ELIGIBILITY INFORMATION: If the answer to any of the following questions is NO, you are not eligible for Assistance. ***Additional pages for other adult household members is attached.***		
Were you or a household member affected by the COVID-19?	☐ YES	☐ NO
How many household members are affected by COVID-19?		
For each Household member affected by COVID-19, provide the following information:		
1st household member AGE 18 AND OVER affected by COVID-19		
Name:		
Are they unemployed or underemployed due to COVID-19?	☐ YES	☐ NO
Date person became unemployed or under employed		
Name and address of employer prior to being impacted by COVID-19:		
What was the annual gross income of this person prior to being affected by COVID-19 or March 1, 2020 whichever is later?		
Current employer:		
What was the projected annual gross income of this household after being affected by COVID-19?		
Is the person receiving unemployment benefits? Yes or No		
If yes, how much are they receiving monthly $		
Provide additional information about Hardship:		

SECTION 4. PROPERTY INFORMATION		
Do you rent or own a pre-1994 mobile or manufactured home?	☐ YES	☐ NO
Are you past due or delinquent on your rent or mortgage?	☐ YES	☐ NO
What is your monthly **RENT** payment?		
What is your monthly **MORTGAGE** payment?		
What are the penalties due, if any?		
How many months of **RENT** are past due?	Amount Due	
How many **MORTGAGE** payments are past due?	Amount Due	
The following question will require a special review to determine eligibility:		
Did you apply for COVID-19 assistance to any other program or organization?	☐ YES	☐ NO
Explain:		

ADDITIONAL COVID-RELATED ASSISTANCE:	
Have you received any COVID related assistance?	☐ Yes ☐No
Amount Approved $ Amount Received to date $	
List agency providing services	1
	2
	3

SECTION 5. INCOME INFORMATION:

Income includes: Wages, salaries and tips, alimony, child support, military income, part-time income, temporary income, TANF, Social Security, unemployment benefits, other benefits for all household members. List ALL household members and their incomes. Attach a separate sheet if you need more space.

FOOD STAMPS ARE NOT CONSIDERED INCOME- do not list food stamps.

Household Member Name	Full Time Student? Y/N	Source of Income (include employer name) If Applicable	Rate of Pay	Payment Basis (hourly, weekly, monthly, etc.)

SECTION 6. ASSET INFORMATION: Provide the requested information on any property you may own or assets you may have.

Do you own any other real estate?	☐ Yes ☐ No ☐ N/A
If yes: Provide address, city and state of property(s):	
What is the tax roll value of the property?	
What is the current balance owed on the mortgage?	
Do you have income from the property? (rental income)	☐ Yes ☐ No
If you answered yes, provide amount of annual rental income	$
Is your primary residence currently in foreclosure?	☐ Yes ☐ No

ASSET INFORMATION CONTINUED.....

List below the types and sources of any household assets: **CHECKING ACCOUNTS, SAVING ACCOUNTS, INVESTMENT ACCOUNTS, RETIREMENT, PROPERTY IN ADDITION TO THE HOMESTEAD.** Automobiles and homestead are not included here. Provide both the current cash value and the estimated annual income from the asset. Provide this information for all household members.

Household Member Name	Type & Source of Asset	Cash Value of Asset	Annual Income from Asset

SECTION 7. ELIGIBILITY RELEASE: It is required that you sign this form (see next page), which allows the City/County, subrecipient, sponsor, State or Vendor to request information from Third Parties concerning your eligibility and participation in this program.

INFORMATION COVERED: Inquiries may be made about items initialed below by the applicant.

INSTRUCTIONS TO APPLICANT: Your signature on this Eligibility Release, and the signatures of each member of your household who is 18 years of age or older, authorizes the City/County or any of its duly authorized representatives to obtain information from a third party regarding your eligibility and continued participation in the CRF Program for disaster assistance. Each adult member of the household must sign this Eligibility Release.

Information provided by the applicant(s) may be subject to Chapter 119, Florida Statutes, regarding Open Records.

SECTION 8. APPLICANT CERTIFICATION:

Certify that all the information in the application is true, to the best of your knowledge. By signing this application to verify the information contained, the applicant authorizes the City/County or any of its duly authorized representatives to verify the information listed herein.

I/We understand the information provided above is collected to determine if I/we are eligible to receive assistance under the CRF program.
I/We hereby certify that all the information provided herein is true and correct.
I/We understand that providing false statements or information for the purpose of obtaining assistance is grounds for termination of housing assistance and is punishable under Chapter 817 of the Florida Statutes as a first-degree misdemeanor.
I/We authorize the above-referenced City/County/subrecipient/sponsor and any of its duly authorized representatives to verify all information provided in this application.
I/We understand that additional information will likely be required to move forward with this program.

APPLICANT AUTHORIZATION:

I authorize the above-named Subrecipient, Sponsor, State or Vendor to obtain information about me and my household that is pertinent to determining my eligibility for participation in the Program. I acknowledge that:
(1) A photocopy of this form is as valid as the original; AND
(2) I have the right to review information received using this form; AND
(3) I have the right to a copy of information provided to the Subrecipient and to request correction of any information I believe to be inaccurate; AND
(4) All adult household members will sign this form and cooperate with the Subrecipient in the eligibility verification process.

Signature of Applicant:	**Date**
Signature of Co-Applicant:	**Date**
Household member age 18+:	**Date**
Household member age 18+:	**Date**
Household member age 18+:	**Date**
Household member age 18+:	**Date**
Household member age 18+:	**Date**
Household member age 18+:	**Date**

Warning: Chapter 817 of the Florida Statutes provides that willful false statements or misrepresentation concerning income and assets or liabilities relating to financial condition is a misdemeanor of the first degree and is punishable by fines and imprisonment provided under §775.082 or 775.083.

Intake Application

Section 3 – Eligibility Information

Additional pages if needed

2nd household member age 18+ affected by COVID-19		
Name:		
Are they unemployed or underemployed due to COVID-19?	☐ YES	☐ NO
Date the person became unemployed or under employed		
Name and address of employer prior to being impacted by COVID-19:		
What was the annual gross income of this person prior to being affected by COVID-19 or March 1, 2020 whichever is later?		
Current employer:		
What was the projected annual gross income of this household after being affected by COVID-19?		
Is the person receiving unemployment benefits? Yes or No		
If yes, how much are they receiving monthly $		
Provide additional information about Hardship:		

3rd household member age 18+ affected by COVID-19		
Name:		
Are they unemployed or underemployed due to COVID-19?	☐ YES	☐ NO
Date the person became unemployed or under employed		
Name and address of employer prior to being impacted by COVID-19:		
What was the annual gross income of this person prior to being affected by COVID-19 or March 1, 2020 whichever is later?		
Current employer:		
What was the projected annual gross income of this household after being affected by COVID-19?		
Is the person receiving unemployment benefits? Yes or No		
If yes, how much are they receiving monthly $		
Provide additional information about Hardship:		

4th household member age 18+ affected by COVID-19		
Name:		
Are they unemployed or underemployed due to COVID-19?	☐ YES	☐ NO
Date the person became unemployed or under employed		
Name and address of employer prior to being impacted by COVID-19:		
What was the annual gross income of this person prior to being affected by COVID-19 or March 1, 2020 whichever is later?		
Current employer:		
What was the projected annual gross income of this household after being affected by COVID-19?		
Is the person receiving unemployment benefits? Yes or No		
If yes, how much are they receiving monthly $		
Provide additional information about Hardship:		

5th household member age 18+ affected by COVID-19		
Name:		
Are they unemployed or underemployed due to COVID-19?	☐ YES	☐ NO
Date the person became unemployed or under		
Name and address of employer prior to being impacted by COVID-19:		
What was the annual gross income of this person prior to being affected by COVID-19 or March 1, 2020 whichever is later?		
Current employer:		
What was the projected annual gross income of this household after being affected by COVID-19?		
Is the person receiving unemployment benefits? Yes or No		
If yes, how much are they receiving monthly $		
Provide additional information about Hardship:		

END of

Intake Application

Self-Certification of Income

1. Read completely

2. ***PLEASE PRINT***.

3. Each individual household member age 18 and over must complete their own form. You will have to make copies of the attached blank form if you have more than one (1) household member age 18 and over.

CRF ASSISTANCE SELF-CERTIFICATION OF INCOME FORM
To be completed by each adult household member

Name _____ County _____

Address _____ Phone # _____

_____ Email _____

1. ☐ I hereby certify that I have been negatively impacted by the **COVID-19** pandemic.

2. ☐ I am underemployed or unemployed.

Explain your COVID-19 related hardship:

I will receive income from the following sources over the next 12 months: (Circle Y (yes) or N (no) for each statement):

Y	N	Gross wages from employment (including commissions, tips, bonuses, fees, etc.)	$_____
Y	N	Net income from operation of a business	$_____
Y	N	Rental income from real or personal property	$_____
		Property Value	$_____
Y	N	Cash value of all assets (checking, savings, CD, stocks, bonds)	$_____
Y	N	Value of whole life insurance policies	$_____
Y	N	Interest or dividends from all assets	$_____
Y	N	Social Security payments, annuities, retirement funds, pensions, or death benefits	$_____
Y	N	Unemployment Benefits	$_____
Y	N	Disability payments	$_____
Y	N	Public assistance payments	$_____
Y	N	Temporary Assistance for needy Families (TANF)	$_____
Y	N	Periodic allowances such as alimony, child support, or gifts received from persons not living in my household	$_____
Y	N	Sales from self-employed resources	$_____
Y	N	Any other source not named above	$_____
Y	N	I currently have no income of any kind and there is no imminent change expected in my financial status or employment status during the next 12 months.	

3. I will be using the following sources of funds to pay for rent and other necessities:

I certify my anticipated gross annual income for the next 12 months to be (Total of section 2): $_____.

I will inform local government staff if my income changes during the period when I am receiving assistance.

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of a lease agreement. The information provided is subject to verification by the county or eligible municipality.

_____ _____

Printed Name Date

_____

Signature

_____ _____

Witness #1 Printed Name Witness #2 Printed Name

_____ _____

Witness #1 Signature Witness #2 Signature

OR

FOR AN OATH OR AFFIRMATION:

STATE OF FLORIDA
COUNTY OF_____

Sworn to (or affirmed) and described before me this_____ day of _____, 2020

by _____.

(NOTARY SEAL)

Signature_____

Personally Known _____OR Produced Identification_____ _____

Type of Identification Produced_____ Name of Notary (Typed, Printed, or Stamped)

END of

Self-Certification Form

Duplication of Benefits Agreement

1. Read completely.

2. ***PLEASE PRINT.***

3. EVERYONE in the household that is age 18 and over must sign this form AND have the signature witnessed.

CRF Duplication of Benefits Agreement

FOR OFFICE USE ONLY!
Whereas, below named Applicant is receiving Florida Housing Finance Corporation (FHFC) Coronavirus Relief Funds (CRF) in the amount of $_____ to provide funding to (pay rent, pay mortgage payments, pay utilities) for the property located at:

Applicant Name_____

Street Address _____

City, State, Zip _____

Now, therefore, the Jurisdiction has an option to recoup assistance used on the above described property upon the terms, conditions and contingencies herein set forth:

Federal Benefits and Charitable Donations
Recipient agrees that if he/she receives further federal benefits, charitable donations, or other financial assistance to (pay rent, pay mortgage payments, pay utilities) in connection with the COVID-19 response, the recipient will report receiving benefits by emailing ***crf@suwanneeec.net*** or calling ***386-362-4115 ext. 242*** within one (1) month of receipt of additional proceeds and/or benefits. If recipient fails to report additional federal benefits or charitable donations, then the Jurisdiction may require immediate repayment in full of the entire amount of assistance provided by the Jurisdiction. Additional assistance sources may include, but are not limited to, FEMA (Federal Emergency Management Administration), CSBG (Community Services Block Grant), Red Cross, United Way, any additional Federal or State program, etc.

Duplication of Benefits
Recipient agrees that if benefits received subsequent to the receipt of CRF funds are a duplication of benefits (DOB) received from other sources such as federal benefits or charitable donations that the following shall apply:

1. If the Award has been fully expended by the City/County, any Subsequent DOB Proceeds shall be repaid by Recipient to the City/County up to the amount of the Award.
2. If no portion of the Award has been expended by the City/County, any Subsequent DOB Proceeds shall be paid by Recipient to the City/County and used to reduce the Award. If the application of the Subsequent DOB Proceeds would reduce the Award to zero, all Subsequent DOB Proceeds and any funds previously paid by the Recipient to the City/County shall be returned to the Recipient, and this Agreement shall terminate.
3. If some portion of the Award has been expended by the City/County, any Subsequent DOB Proceeds shall be used, retained and/or disbursed in the following order: (1) Subsequent DOB Proceeds shall first be paid by Recipient to the City/County to reduce the unexpended portion of the Award; (2) if the application of the Subsequent DOB Proceeds would reduce the unexpended Award to zero, any remaining Subsequent DOB Proceeds shall be applied to expended portion of the Award and retained by the City/County; (3) if the application of the Subsequent DOB Proceeds reduces both the unexpended and the expended portions of the Award to zero, any remaining Subsequent DOB Proceeds shall be returned to the Recipient, and this Agreement shall terminate.
4. If the City/County makes the determination that the Recipient does not qualify to participate in the Program or the Recipient decides not to participate in the Program, the Subsequent DOB Proceeds and any funds previously paid by the Recipient to the City/County that have not been used or obligated by the Program shall be returned to the Recipient, and this Agreement shall terminate.
5. Once the City/County has recovered an amount equal to the Award, the City/County will reassign to Recipient any rights assigned to the City/County pursuant to this Agreement.

Income Eligibility
Recipient certifies that he/she has provided complete, accurate, and current information regarding household income to demonstrate Recipient's eligibility to receive CRF funds.

Enforcement
The Recipient and the Jurisdiction acknowledge that the Jurisdiction has the right and responsibility to enforce this agreement.

Whereas, if the Recipient does not violate any of the terms listed in this agreement, then this agreement will be considered released upon the expenditure of the commitment of funds, or December 30, 2020, whichever occurs first.

IN WITNESS WHEREOF, the undersigned recipient(s) has/have affixed his/her signature(s) and seal(s) this _____ day of _____, 2020.

Signed, sealed and delivered in the presence of:

_____	_____
Witness to Applicant	Applicant
_____	_____
Witness to Co-Applicant	Co-Applicant
_____	_____
Witness to HH Member	Household Member age 18 or over
_____	_____
Witness to HH Member	Household Member age 18 or over
_____	_____
Witness to HH Member	Household Member age 18 or over
_____	_____
Witness to HH Member	Household Member age 18 or over
_____	_____
Witness to HH Member	Household Member age 18 or over

END of

Duplication
Of
Benefits Form

END of

CRF Disaster Assistance Packet