

Gilchrist County S.H.I.P.

(State Housing Initiative Partnership)

Repair Assistance

For assistance or questions:

Suwannee River Economic Council, Inc.
SHIP Administration staff

1. Bailey Edwards, SHIP Program Assistant

386-362-4115 ext. *245

bedwards@suwanneec.net

2. Amanda Lamb, SHIP Coordinator

Office- 386-362-4115 ext.*233

Work Cell- 386-688-0074

alamb@suwanneec.net

3. Stephanie Barrington, SHIP Director

386-362-4115 ext. *242

sbarrington@suwanneec.net



APPLICATION INSTRUCTIONS

1. **PLEASE PRINT!**

2. Fill in all blanks. If the information requested is not applicable to you, write "N/A"

3. Return the complete SHIP application packet in one of the following ways:

Mail to: SREC, Inc.
 SHIP DEPT.
 POB 70
 LIVE OAK FL 32064

OR

Scan the documents into a PDF format and email to sbarrington@suwanneeec.net

4. After your application packet has been received you will be placed on the waiting list. At such time as your application has been pulled for servicing, you will be contacted by a member of the SHIP Department to begin the required income verification process to determine if you are eligible for the program.

5. Once the income verification process is complete you will either receive a decline notice stating the reason for the decline or you will receive a phone call from our Housing Estimator to schedule an appointment for him to come to your home for an initial property inspection.

S.H.I.P. INCOME LIMITS

GILCHRIST COUNTY

Effective 4/1/2024

INCOME CATEGORY	NUMBER OF HOUSEHOLD MEMBERS							
	1	2	3	4	5	6	7	8
Extremely Low	\$20,050	\$22,900	\$25,820	\$31,200	\$36,580	\$41,960	\$47,340	\$52,720
Very Low	\$33,350	\$38,150	\$42,900	\$47,650	\$51,500	\$55,300	\$59,100	\$62,900
Low	\$53,400	\$61,000	\$68,650	\$76,250	\$82,350	\$88,450	\$94,550	\$100,650

NOTE: Figures represent maximum household income for each income level per number in household.

GILCHRIST COUNTY SHIP RULES

1. Maximum SHIP participation for Emergency Repair - \$7,500
(Extremely Low and Very Low income categories only.)
2. Maximum SHIP participation for Owner Occupied Rehab:
Extremely Low and Very Low income categories: \$40,000
Low income category: \$29,000
3. Some mobile homes may be eligible for wheelchair ramps only depending on year of manufacturing and funding availability.
4. Applications must be accompanied by proof of ownership through the one of the following documents:
 - Warranty Deed
 - Quit-Claim Deed
 - Homestead Exemption
 - Tax Records
 - Life Estate Documents
5. For the complete Local Housing Assistance Plan, the public document setting forth the regulations of the County's SHIP program, visit www.floridahousing.org.

APPLICANT PRINTED NAME

APPLICANT SIGNATURE

DATE

**GILCHRIST COUNTY S.H.I.P. PROGRAM
 APPLICATION FOR HOUSING REPAIR ASSISTANCE**

Gross Annual Household Income: \$ _____

	Applicant / Head of Household (HOH)	Co-Applicant / Add'l Adult Household Member
Full Name		
E-mail		
Date of Birth/Age		
Cell Phone		
Home Phone		
Street Address		
Mailing Address if different		

Other Household Members (list ALL additional household members):

Name(s)	Date of Birth / Age	Relationship to Applicant / HOH

Is Applicant, Co-Applicant, or any other household member, age 18 or older, a full-time student? If yes, please list the educational institution and provide enrollment documentation _____

Employment Information (If unemployed or retired, state it here.) NOTE: Attach additional sheets as necessary for all household members 18 years and over.

Applicant / HOH Name:	Employer Name:
Position:	Supervisor:
Address:	Time Employed:
Phone: Pay Rate:	Pay Frequency:
Annual Income (gross salary, overtime, tips, bonuses, etc.): \$	

Co-Applicant / Add'l Adult Household Member Name:	Employer Name:
Position:	Supervisor:
Address:	Time Employed:
Phone: Pay Rate:	Pay Frequency:
Annual Income (gross salary, overtime, tips, bonuses, etc.): \$	

Other sources of income (For ALL household members including minors list business or rental net income, child support, alimony, Social Security, retirement, pensions, unemployment or workers compensation, public assistance payments, etc.)

	Name	Type of Income	Gross Annual Amount
1.			
2.			
3.			
4.			
5.			
			Total \$

Assets and asset income (For ALL household members including minors, list checking and savings accounts, IRA's, CD's, life insurance, bonds, stocks, equity in properties in addition to homestead, etc. Do not include homestead property.)

	Type of Asset	Asset Value	Bank / Account #	Annual Asset Income
1.				
2.				
3.				
4.				
5.				

Liabilities (For ALL household members 18 and over list all charge accounts including credit cards, store charge accounts, etc., and all loans including auto, real estate, mortgage loans, etc.)

	Type Credit / Loan	Creditor's Name	Balance Owed	Monthly Payment
1.				
2.				
3.				
4.				
5.				

Ethnicity/Special Needs (For reporting purposes only, please check all that apply for Head of Household only:

White _____ Black _____ Hispanic _____ Asian/Pacific Islander _____

Native American _____ Farmworker _____ Disabled or Disabled Minor _____ Elderly _____

Homeless _____ Special Needs _____ Other _____

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 or 775.83. 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.

Applicant Signature	Printed Name	Date
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Co-Applicant Signature	Printed Name	Date
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Household member Signature (over 18)	Printed Name	Date
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Household member Signature (over 18)	Printed Name	Date
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Household member Signature (over 18)	Printed Name	Date
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ASSET ADDEMDUM TO APPLICATION

Must be completed for **ALL** household members.

In order to properly qualify and applicant for S.H.I.P. assistance, the following asset information for **all persons, including minors, who will occupy assisted housing**, must be obtained. This information will be used for qualification purposes only.

Assets include, but are not limited to:

Cash held in savings and/or checking accounts, safe deposit boxes, homes, etc.; trust funds (revocable trusts); equity in real estate and other capital investments; stocks, bonds, treasury bills, certificates of deposit, money market and other investment accounts; IRA, Keogh and similar accounts; retirement and pension funds; cash value of life insurance policies available to the individual before death; mortgage or deed of trust; lump sum receipts (i.e. lottery winnings, inheritances, victim's restitution, insurance claims or settlements, etc.) and, personal property held as an investment (i.e. gem or coin collections, painting, antique cars, etc.).

NOTE: Do not include necessary property such as clothing, furniture, cars, wedding bands, etc.

Certification (NOTE: ALL assets and their amounts will be verified.):

I / We hereby state that the combined value of my / our assets (check one):

I / we do not have any assets at this time.

Does NOT exceed \$5,000

Does exceed \$5,000

Total value of assets: \$ _____

Total annual income expected to be derived from assets: \$ _____

Applicant Signature

Printed Name

Date

Co-Applicant Signature

Printed Name

Date

Household member Signature (over 18)

Printed Name

Date

Household member Signature (over 18)

Printed Name

Date

Household member Signature (over 18)

Printed Name

Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby authorize the release without liability information regarding my employment, income, and / or assets to:

SUWANNEE RIVER ECONOMIC COUNCIL, INC.

for the purposes of verifying information provided as part of determining eligibility for assistance under the SHIP Program. I understand that only information necessary for determining eligibility can be requested.

I understand that previous or current information regarding me 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 / saving accounts, stocks, bonds, certificates of deposits, IRA's and other investment accounts, interest, and dividends; Payments from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits, unemployment, disability or worker's compensation, and welfare assistance; Net income from the operation of a business; and Alimony or child support payments.

Organization / individuals that may be asked to provide verifications are, but not limited to: Past / present employers, banks, financial or retirement institutions, unemployment agency, welfare agency, alimony / child support providers, Social Security Administration, Veteran's Administration, and others.

Agreement to Conditions:

I _____ (PRINT NAME) agree that a photocopy of this authorization may be used for purposes stated above. I understand that I have the right to review this file and correct any information found to be incorrect.

Signature

Date

ALL household members age 18+ must complete this page individually. Make additional copies if needed.