Lafayette County S.H.I.P.

(State Housing Initiative Partnership)

Repair Assistance

Contact information:

Suwannee River Economic Council, Inc.
SHIP Administration staff

1. Bailey Edwards, SHIP Program Assistant
386-362-4115 ext. *245
bedwards@suwanneeec.net

2. Amanda Lamb, SHIP Coordinator
Office- 386-362-4115 ext.*233
Work Cell- 386-688-0074
alamb@suwanneeec.net

3. Stephanie Barrington, SHIP Director
386-362-4115 ext. *242
sbarrington@suwanneeec.net

SHIP
housing a stronger Florida

APPLICATION INSTRUCTIONS

1. **PLEASE PRINT!**

2. Fill in all blanks. If the information requested is not applicable to you, write "N/A". See yellow highlights for instructions and additional explanations.

3. Return pages 1 – 9 of the SHIP application in one of the following ways:

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

   OR

   - Mail to: SREC, Inc.
     ATTN: SHIP
     POB 70
     Live Oak FL 32064

4. All applications are placed on a waiting list. When your application is pulled for processing, the SHIP Coordinator will email the ***Applicant's*** email address listed on the application.

5. Once the income verification process is complete you will either receive a decline letter stating the reason for the decline, or a phone call from our office to schedule an appointment for the Housing Estimator to perform an initial inspection on the home.

S.H.I.P. INCOME LIMITS
LAFAYETTE COUNTY
Effective 5/1/2026

INCOME CATEGORY	NUMBER OF HOUSEHOLD MEMBERS							
	1	2	3	4	5	6	7	8
Extremely Low	$16,450	$21,640	$27,320	$33,000	$38,680	$44,360	$48,550	$51,700
Very Low	$27,400	$31,350	$35,250	$39,150	$42,250	$45,400	$48,550	$51,700
Low	$43,850	$50,100	$56,350	$62,600	$67,650	$72,650	$77,650	$82,650

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

LAFAYETTE COUNTY S.H.I.P. RULES

1. Maximum SHIP participation for Emergency Repair is $20,000. Maximum SHIP participation for Owner Occupied Rehab is $40,000. Extremely Low, Very Low, and Low income categories only. Income that exceeds the Low income category is not eligible. See Income Limits on previous page.

2. Applicants will be required to prove ownership. Rental property or property not in the Applicant's or Co-Applicant's name is not eligible. Mobile home applicants must own the home and the land.

3. Some mobile homes manufactured after 1994 may be eligible for assistance depending on funding availability. If the mobile home was manufactured prior to 1994 it is not eligible for assistance.

4. 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

LAFAYETTE 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? Yes ____ No____

If yes, 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 age 18+.***

Applicant / HOH Name:	Employer:
Position:	Employer Address:
Time employed:	Supervisor Name:
Pay rate: Pay frequency:	Supervisor Phone:
Estimated annual gross income (salary, overtime, tips, bonuses, etc.):	

Co-Applicant / Add'l Adult Household Member Name:	Employer:
Position:	Employer Address:
Time employed:	Supervisor Name:
Pay rate: Pay frequency:	Supervisor Phone:
Estimated annual gross income (salary, overtime, tips, bonuses, etc.):	

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

	Household member name	**Type of income**	**Gross annual amount**
	(EXAMPLE) *James Smith*	*Social Security Disability*	*$11,500*
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**	**Institution Name**	**Annual Asset Income**
	(EXAMPLE) *Checking*	*$1500*	*First Bank*	*$0.00*
1.				
2.				
3.				
4.				
5.				

Liabilities ***(For ALL household members age 18+ 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
	(EXAMPLE) *Car*	*The Auto Place*	*$12,500*	*$320*
1.				
2.				
3.				
4.				
5.				

Ethnicity/Special Needs ***(For reporting purposes only, please check all that apply for Applicant / HOH only)***

White [ ] Black [ ] Hispanic [ ] Native American [ ] Asian/Pacific Islander [

Farmworker [ ] Elderly [ ] Homeless [ ] Special Needs [ ] Disabled or Disabled Minor [ ]

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 / HOH 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

ASSET ADDEMDUM TO APPLICATION

To qualify an applicant for S.H.I.P. assistance, the following asset information for **all persons, including minors, who will occupy the assisted household,** 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 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 / HOH 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 purpose 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

Do not include multiple signatures on this form. Make a copy of this page for each individual household member age 18+ as needed. Each person must sign their own form.

INTERNAL APPEALS PROCESS

The written appeal system has been adopted by the Board, posted in the Subgrantee's agency and posted for those applying for service. In the event of a complaint/appeal, the complaint/appeal shall first be heard by the Programs Director. Should the first designated party be unable to resolve the difficulty, the second complaint/final appeal will be heard by the Executive Director.

_____

Applicant / HOH Printed Name

_____ _____

Applicant / HOH Signature Date

Current Liens/Mortgages Statement

Applicant / HOH Printed Name _____

Property Street Address _____

Property City, State, Zip _____

I hereby attest that I do not have any existing liens/mortgages on the above property.

OR

I hereby attest the following liens/mortgages existing on the above property:

1 _____
Name of Lien/Mortgage Holder *Amount Owed*

2 _____
Name of Lien/Mortgage Holder *Amount Owed*

3 _____
Name of Lien/Mortgage Holder *Amount Owed*

_____
Applicant / HOH Signature

_____
Date

Income Producing Property

Applicant / HOH Printed Name _____

Property Street Address _____

Property City, State, Zip _____

I hereby attest the above listed property is/will not be used as an income producing property for rental income, or business income based on day/child care, personal services, retail services, or similar activities that require regular and ongoing visits by clients and/or customers to the property

_____

Applicant / HOH Signature

_____

Date