Client Registration

Date______________

Number of People in Household: ______

Demographic Information for Head of Household

Name	Date of Birth	Gender	Primary Race	Secondary Race	Disabled?	Family Type
First: ______________ Middle: ______________ Last: ______________	____/____/____	❑ Female ❑ Male ❑ Transgender ❑ Other ___________ ❑ Don't know ❑ Refused	❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ Other/Multi-Racial ❑ White ❑ Decline to state	❑ American Indian/Alaska Native ❑ Asian ❑ Black ❑ Native Hawaiian/ Pacific Islander ❑ White ❑ Decline to state	❑ Yes ❑ No	❑ Adults (no children) ❑ Grandparent(s) & child ❑ Non-custodial caregiver(s) ❑ Single Parent ❑ Two Parents ❑ Other
	Social Security	**Ethnicity**			**Veteran?**	
	______-______-______	❑ Hispanic ❑ Non-Hispanic			❑ Yes ❑ No	

Have you visited any other pantry in the last 30 days?_______________

Address	Apt.	City	Zip Code	County	Phone Number	Email

Household Housing Information		Housing Status
Where did you stay last night?)		☐ Literally homeless
☐ Room, apartment, or house that you rent	☐ Staying in family member's apartment/house	☐ Imminently losing housing
☐ Emergency shelter	☐ Psychiatric hospital or other psychiatric facility	☐ Unstably housed and at-risk of losing housing
☐ Hotel or Motel	☐ Substance abuse treatment facility or detox center	☐ Stably housed
☐ Room, apartment, or house that you rent	☐ Foster care home or group home	
☐ Apartment or house that you own	☐ Hospital (non-psychiatric)	
☐ Transitional housing for homeless persons	☐ Place not meant for habitation (car, abandoned building, outside, etc.)	

For Office Use Only

HOH HMIS ID _______________ Pantry Appointment time_______________

Demographic Information for Additional **Household Members**

Name	Date of Birth	Gender	Race	Disabled?	Relationship to Head of Household
First: ______ Middle: ______ Last: ______	___/___/___	❑ Female ❑ Male ❑ Transgender ❑ Other_______ ❑ Client doesn't know ❑ Client refused	❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ Other/Multi-Racial ❑ White ❑ Decline to state	❑ Yes ❑ No	❑ Spouse ❑ Child ❑ Stepchild ❑ Friend ❑ Partner ❑ Grandchild ❑ Other relative ❑ Other
	Social Security	**Ethnicity**		**Veteran?**	
		❑ Hispanic ❑ Non-Hispanic		❑ Yes ❑ No	

Name	Date of Birth	Gender	Race	Disabled?	Relationship to Head of Household
First: ______ Middle: ______ Last: ______	___/___/___	❑ Female ❑ Male ❑ Trans Female ❑ Trans Male ❑ Don't know	❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ Other/Multi-Racial ❑ White ❑ Decline to state	❑ Yes ❑ No	❑ Spouse ❑ Child ❑ Stepchild ❑ Friend ❑ Partner ❑ Grandchild ❑ Other relative ❑ Other
	Social Security	**Ethnicity**		**Veteran?**	
		❑ Hispanic ❑ Non-Hispanic		❑ Yes ❑ No	

Name	Date of Birth	Gender	Race	Disabled?	Relationship to Head of Household
First: ______ Middle: ______ Last: ______	___/___/___	❑ Female ❑ Male ❑ Transgender ❑ Other______ ❑ Client doesn't know ❑ Client refused	❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ Other/Multi-Racial ❑ White ❑ Decline to state	❑ Yes ❑ No	❑ Spouse ❑ Child ❑ Stepchild ❑ Friend ❑ Partner ❑ Grandchild ❑ Other relative ❑ Other
	Social Security	**Ethnicity**		**Veteran?**	
		❑ Hispanic ❑ Non-Hispanic		❑ Yes ❑ No	

Name______________________

Household Income Information

If your household gross income is at or below the income listed for the number of people in your household, you are eligible to receive food.

Household Size	Annual Income	Monthly Income	Twice per Month	Every two Weeks	Weekly Income
1	$25,520	$2,127	$798	$982	$491
2	$34,480	$2,873	$1,078	$1,328	$664
3	$43,440	$3,620	$1,358	$1,253	$836
4	$52,400	$4,367	$1,638	$2,016	$1,008
5	$61,360	$5,113	$1,918	$2,360	$1,180
6	$70,320	$5,860	$2,198	$2,706	$1,353
7	$79,280	$6,607	$2,478	$3,050	$1,525
8	$88,240	$7,353	$2,758	$2,546	$1,697
For each additional family member add:	$4,480	$373	$126	$186	$93

Please indicate the amount received and by whom (For the past 30 days)
HOPE Requires Proof of Income

Monthly Income		Non-Cash Benefits		Expenses	
Earned Income	$	Food Stamps	$	Bus Pass/ Uber/Lyft	$
Unemployment	$	Medicaid	☐	Car Payment	$
Social Security (SSI)	$	Medicare	☐	Child Care	$
Social Security Disability (SSDI)	$	Healthy Kids	☐	Child Support Expense	$
VA Disability	$	WIC	☐	Electricity	$
Private Disability	$	VA Medical	☐	Food	$
Worker's Compensation	$	TANF Child Care	☐	Gas/Heating	$
Public Assistance (TANF)	$	TANF Transportation	☐	Gas (Car)	$
Veteran's Pension	$	Section 8	☐	Car Insurance	$
Pension	$	Other:	$	Medical	$
Child Support	$			Miscellaneous	$
Alimony/ Spousal Support	$			Mortgage/Rent	$
Other:	$			Home/Renter's Insurance	$
				Sewage/Trash	$
Other:	$			Phone	$
				Water	$
				Cable/Internet/ Streaming Services	$
Total Income	$	**Total Benefits**	$	**Total Expense**	$

EMERGENCY ASSISTANCE REQUEST

State Specific Need	☐ Food ☐ Rent/Mortgage Assistance ☐ Utility Assistance ☐ Hygiene Products ☐Thrift store voucher ☐Financial Counseling ☐Case Management ☐ Other
State why income is not available to pay monthly expenses:	

How did you hear about HOPE?

- Friend/Family ☐ / 211 ☐
- Church *(Name of Church:)* ____________________
- Other *(Please Specify:)* ____________________

Applicant Certification/Release of Information

I certify that all information I have provided above is true and correct. I consent to the release of information contained in this request to HOPE Helps, Inc, other local social service agencies, and/or funders who distribute emergency financial assistance, and/or to the vendor receiving these funds, as necessary to complete services to my household, provide statistics on emergency assistance and as a guard against duplication of assistance. I also certify that if I or anyone in my household has been given emergency financial assistance in the past, I have advised the caseworker in this agency of that information.

I have read the Applicant Certification/Release of Information statement and understand it. **Signature:**____________________	**Date:**

OFFICE USE ONLY

Authorized Agency: ____________________

Caseworker Name ____________________ **Caseworker Phone #** ____________________

Fund ____________________ **Service** ____________________

Amount **$** ____________________ **Reason** ____________________

Vendor ____________________ **Account #:** ____________________

Payee ____________________ **Mail Check to Payee:** ☐

Address ____________________

Authorized Signature ____________________ **Date:** ____________________

Continuum of Care FL-507 | Homeless Services Network of Central Florida
Client Informed Consent & Authorization for Release of Information in HMIS

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions or desire any further information regarding this form, please contact the system administrator via the HSN HMIS Help Desk by phone (407-893-0133 x640) or by submitting a ticket on our website (https://hmiscfl.org).

1. In order to best serve your needs at HOPE Helps, Inc. to develop meaningful treatment plans, to determine your continuing eligibility for services, and to monitor your progress in complying with the terms of your shelter, housing or other services, HOPE Helps, Inc. and the Continuum of Care need to exchange, share, and/or release data, information or records they may collect about you.

2. The information contained in your case records with any Agency is considered confidential and privileged and cannot be exchanged, shared and/or released without your express and informed written consent, except where otherwise authorized by law. Please understand that access to shelter, housing and services is available without your consent for the release of the information. However, your consent to share information with other service agencies is a critical component of our community's ability to provide the most effective services and housing possible.

3. I understand that:
   a) This Agency may <u>not</u> refuse to serve me simply because I do not want my information shared with other service agencies.
   b) This form specifically authorizes the use of information about me in research conducted using information maintained in the HSN HMIS. I will not be personally identified by name, social security number, or any other unique characteristic in published research reports. The type of research that will be conducted using this information includes reports on the number and characteristics of people using different types of services, the effectiveness of services, and changes in patterns over time.
   c) If I give permission, the HSN HMIS will allow information about me, including records previously entered into the HSN HMIS, to be shared among HSN HMIS Partner Agencies. This may include, but is not limited to, my photograph, information regarding my education history and employment background, income, program eligibility and participation, and personal history. The purpose of sharing information is to help the agencies from which I seek services to obtain information about me faster, to assist with my case management, and to connect me more quickly with the services I need.
   d) Agencies that join the HSN HMIS after I sign this consent/authorization also will have access to the personal information that I authorize for data sharing. This Agency must make reasonable accommodations to allow me to view the updated list of HSN HMIS Partner Agencies.
   e) I understand that I have the right to inspect, copy, and request all records maintained by an Agency relating to the provision of services provided by an Agency to me and to receive a copy of this form unless specifically denied under federal or state law. I understand that my records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise authorized by law. I understand that this release is valid for three years from the date I sign this document. I may revoke this authorization at any time verbally or by written request, but the cancellation will not be retroactive.

I give my consent to the exchange of information via the HSN HMIS: Yes ☐ No ☐

☐ **I have read this document or it was read and/or explained to me and I fully understand and agree with the terms of this document.**

Name and Signature of Guardian / Client	**Name and Signature of Witness**
(Print)	(Print)
(Signature) (Date)	(Signature) (Date)

HOPE Helps Inc.
Authorization to Release Information

Name of Head of Household: ______________________________

Household Members	Relation to Head of Household	Age

This release is a **consent** to allow HOPE Helps Inc. staff/representatives to receive/access information from participating partners, employers, landlords/property managers, vocational training providers, public and private education/assistance institutions, physician, hospital, and other entities with which HOPE Helps Inc. interacts on behalf of the head of household and other household members as referenced above. **This release includes access to any health (mental or physical) and social media information, when necessary, for eligibility documentation or to determine achievements of case plan.** The purpose of exchanging information will solely be used to support and document the activities, outcomes, and post exit information (assessing, planning, and facilitating the delivery of services); further, signature is an understanding that there may be on-going discussion and sharing of information as necessary to provide for continued services. The methods used to share information can be verbal, written, and/or computer data transfer.

Signature indicates an understanding to release and hold harmless HOPE Helps Inc. and its employees or any of the above mentioned entities with which the HOPE Helps Inc. interacts on my behalf from any and all liability and claims of any kind related to this release. I further acknowledge receiving a copy of this authorization to release information. This information can include, but is not limited to, academic status and performance, employment status, skill assessment information, and/or services provided by other private or government agencies.

This Release of Information will expire 3 years from the date of signature. Signature of head of household/other adult members (parent or legal guardian) conforms as a valid agreement to release information for household members under the age of 18.

Signature below indicates acceptance of the above stated (all adults must sign release):

Head of Household (Print Name): ______________________________
Signature: ______________________________ **Date:** __________

Other Adult (Print Name): ______________________________
Signature: ______________________________ **Date:** __________

Other Adult (Print Name): ______________________________
Signature: ______________________________ **Date:** __________

Verified by:
HOPE Helps Staff/Volunteer: ______________________________
Signature: ______________________________ **Date:** __________

HOPE's Food Pantry Rules and Regulations

1. HOPE Helps serves Seminole County residents. Our clients may receive food **once** per week. We have emergency food and referral services for out-of-county residents.
2. Clients are able to choose from two food pantry options at HOPE. For the first option, clients may choose to complete a TEFAP form and receive a pre-packed bag of food. For the second option, clients must bring in requested documents (including proof of residency and proof of income), meet with a case manager and participate in financial counseling. The second option also allows you to go through the food pantry and choose your items.
3. The pantry is open **Tuesdays & Thursdays from 9:00 AM-2:00 PM and Wednesdays from 9:00 AM-12:00 PM.** In order to respect our volunteers' time, the pantry ends promptly at closing time.
4. If a different pantry day/time is needed, clients must **call 321-765-4984** to see what's available. If an alternate time is not available they will receive a pre-packed bag of food.
5. All clients must park in the designated client parking area. Clients are not allowed to park at neighboring facilities. Due to limited parking spaces, clients may not be allowed to park if arriving more than 20 minutes prior to their appointment time.
6. HOPE's Resource Center can provide toiletries upon request to each household once every 4 weeks. We rely on donations for this service so what we have to offer will vary weekly.
7. Resource staff must be updated with any change in address or number of people living in the household.
8. Any children brought to HOPE's property must be supervised by parents/guardians at all times.
9. **No TOBACCO or other DRUGS of any kind are to be consumed on HOPE's property**. This includes driveway and parking areas.
10. HOPE looks forward to working with you in mutual kindness, dignity, and respect.

By signing, you are accepting the rules and regulations established by HOPE. Failure to abide by the rules will be sufficient reason to deny services offered by HOPE.

______________________________ ______________________

Print Name Date

____

Client Signature

Optional: I authorize ______________________________ to shop in the pantry on my behalf when I am unable to attend in person.

Rev. 10-12-2021

Release and Hold Harmless

I, ______________________ , my successors and assigns, hereby agree to save and hold harmless HOPE Helps Inc., HOPE Helps Thrift Store (The HOPE Chest), HOPE Helps Food Pantry, any of their departments, agencies, officers, or employees, all of whom while working within their respective authority, from all cost, injury and damage incurred by any of the above, and from any other injury or damage to any person or property whatsoever, any of which caused by an activity, condition or event arising out of the performance, preparation for performance or nonperformance of any provision of this agreement by any entities providing said food, from any liability for the food I receive from the above mentioned food pantry. The above cost, injury, damage or other injury or damage incurred to or by any of the above shall include, in the event of an action, court costs, expenses of litigation and reasonable attorney's fees. This Release and Hold Harmless clause is not intended to indemnify against any cost or damage, or position thereof, caused by HOPE Helps Inc., The HOPE Chest, HOPE Helps Food Pantry, any of its departments, agencies, officers, employees, or relationships.

Signature: ______________________________________ Date: _________________

Staff Signature: __________________________________ Date: _________________

Program
Certification & Agreement

Head of Household: ____________________

NOTE: Non-compliance with program guidelines, case plan, and/or eligibility disqualifiers (such as income guidelines), overrides the certification period.

Certification Period: ____________ to ____________

Initials	Please carefully read each of the following statement below:
	I/We, certify that all of the information provided is true and complete, to the best of my knowledge. I/we understand that withholding information, providing false or misleading information can result in disqualification from the Program. **IMPORTANT: If found to have provided false or misleading information, my household may be banned from receiving services from HOPE Helps, Inc. for a period of three (3) years.**
	I/We, declare that I/we have no other financial resources, and no other support network such as family, friends, religious, social or community groups to assist me and my family at this time.
	I/We understand that in order to receive assistance from the Program, I must reside in Seminole County.
	I/We agree that I/we must report any changes in my household and/or income to my case manager **within five (5) working days** from when it occurred. Changes to my household include, but are not limited to: adding/removal of household members, attainment/loss of employment, and increase/ reduction of employment hours.
	I/We agree to meet with the case manager/financial counselor at a **minimum of three times per certification period** to discuss progression with case plan (goals and deadlines), and to complete a budget. **If it is determined that my household is not progressing or making very minimal positive improvements – my/our case may change from full pantry services to a pre-packed bag only until program compliance is achieved.**

	I/We understand that **program participation is mandatory for all adult household members**. All adult household members will be assigned to seek employment (if not employed), apply for food stamps (if applicable), earnestly work their case plan (If assigned), and/or to attend employability workshops/trainings with the goal of increasing my/our ability to reach self-sufficiency.
	I/We understand that **ONLY** if I/we are in full compliance with the case plan, the funding is available, **AND** I/we meet the funding criteria and requirements – the Program will review the case for assistance. I/We, understand that this is a limited assistance and that the goal of the program is to help me/us increase my/our ability to be self-sufficient. **I/We understand that no on-going assistance is guaranteed.**
	I/We also understand that in order to continue to receive the program benefits, I/we will be subject to periodic re-certifications of guidelines and review of case plan to determine compliance and eligibility.
	I/We understand that if I fail to make satisfactory progress on my case plan I will not be eligible to participate in any future outreach events at HOPE until establishing and making progress on a case plan.

DO NOT SIGN THIS DOCUMENT IF YOU HAVE NOT READ THE STATEMENTS ABOVE – IT IS YOUR RESPONSIBILITY TO READ, ASK QUESTIONS, AND UNDERSTAND THIS DOCUMENT BEFORE AGREEING TO THESE TERMS.

Signature below indicates acceptance of the above stated (all adults must sign this document):

Head of Household (Print Name): ______________________________

Signature: ______________________________ **Date:** ______________

Other Adult (Print Name): ______________________________

Signature: ______________________________ **Date:** ______________

Other Adult (Print Name): ______________________________

Signature: ______________________________ **Date:** ______________

Verified by:

Case Manager: ______________________________

Signature: ______________________________ **Date:** ______________

EXHIBIT "H"
CDBG FAMILY ELIGIBILITY FORM
Hope Helps, Inc.
Special Economic Development Acquisition
2015-2016

Household Information

Household name: ____________________ Household size: __________

Household members (list): ____

____

____

Head of Household Demographic Information

_____ White _____ Black/African American _____ Black/African American & White

_____ Asian _____ Asian & White _____ American Indian or Alaskan Native

_____ American Indian, Alaskan & White _____ American Indian, Alaskan & Black

_____ Native Hawaiian/Other Pacific Islander _____ Other/Multi-Racial

Head of Household Hispanic Ethnicity: _____ YES _____ NO

Income Information

Annual (gross) income (total of all household members): $ ____________________

Participant Certification of Household Information and Income

I/we certify that this information is complete and accurate. I/we agree to provide, upon request, documentation on all income sources to HOPE Helps ____________(Agency Name).

Participant Signature ____________________________ Date __________

WARNING: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government

Agency Certification of Eligibility for the CDBG Program

The purpose of this form is to certify that _______________________(Participant Name), a resident of Seminole County, residing at ____ ______(address) receives benefits under Community Development Block Grant (CDBG) Program.

To determine if program applicants are income-eligible, grantees have several options (please select one):

______ The annual income of this household has been examined and determined to be below $___________________ (income limit for the program for a family of ____ [household size]).

______ The participant household/person assisted qualified under another program having income qualification criteria at least as restrictive as that used in the definitions of LMI household/person, such as Job Training Partnership Act (JTPA) and welfare programs; or

______ Obtain a referral from a state, county or local employment agency or other entity that agrees to refer individuals it determines to be LMI persons based on HUD's criteria and agrees to maintain documentation supporting these determinations.

______ Presumed Benefit - activity benefits a clientele who are generally presumed to be principally low- and moderate-income persons. _ abused children _______ battered spouses _____ elderly persons _______ severely disabled adults ___ homeless persons _____ illiterate adults _______ persons living w/AIDS _______ migrant farm workers

Certified by:

Signature of Agency Representative _________________________ Date ______________

Name (Print)

WARNING: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government

End of Exhibit "H"