Client Registration

Date_____

Number of People in Household: _____

Demographic Information for Head of Household

Name	Date of Birth	Gender	Race/Ethnicity	Disabled?	Family Type
First: _____ Middle: _____ Last: _____	___/___/___	❑ Female ❑ Male ❑ Transgender ❑ Culturally Specific Identity (e.g. Two Spirit) ❑ Non Binary ❑ Questioning ❑ Different Identity ❑ Decline to state	❑ American Indian/Alaska Native or Indigenous ❑ Asian or Asian American ❑ Black, African American, African ❑ Hispanic/Latina/e/o ❑ Middle Eastern or North African ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Additional Race and Ethnicity Detail	❑ Yes ❑ No	❑ Adults (no children) ❑ Grandparent(s) & child ❑ Non-custodial caregiver(s) ❑ Single Mom ❑ Single Dad ❑ Two Parents ❑ Multigenerational ❑ Other _____
	Social Security	**Veteran?**			
	____-____-____	❑ Yes ❑ No			

Client's Address	Apt.	City	Zip Code	County	Client's Phone Number	Client's Email

Emergency Contact	Housing Status
-Name:_____ -Phone #:_____ -Relationship to Head Of Household ☐ Emergency ☐ Guardian ☐ Best Friend ☐ Primary Care Giver ☐ Relative ☐ Mentor ☐ Other _____	☐ Literally homeless. Where did you stay last night? _____ ☐ Imminently losing housing ☐ Unstably housed and at risk of losing housing ☐ Stably housed

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HOH HMIS ID _____ Pantry Appointment time_____ **Group A or B or C**

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Demographic Information for Additional **Household Members**

Name	Date of Birth	Gender	Race/Ethnicity	Disabled?	Relationship to Head of Household
First: ____ Middle: ____ Last: ____	___/___/___ **Social Security** ___-___-___	❑ Female ❑ Male ❑ Transgender ❑ Culturally Specific Identity (e.g. Two Spirit) ❑ Non-Binary ❑ Questioning ❑ Different Identity ❑ Decline to state ____ **Veteran?** ❑ Yes ❑ No	❑ American Indian/Alaska Native or Indigenous ❑ Asian or Asian American ❑ Black, African American, African ❑ Hispanic/Latina/e/o ❑ Middle Eastern or North African ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Additional Race and Ethnicity Detail	❑ Yes ❑ No	❑ Spouse ❑ Child ❑ Stepchild ❑ Friend ❑ Partner ❑ Grandchild ❑ Other Relative ❑ Other

Name	Date of Birth	Gender	Race/Ethnicity	Disabled?	Relationship to Head of Household
First: ____ Middle: ____ Last: ____	___/___/___ **Social Security** ___-___-___	❑ Female ❑ Male ❑ Transgender ❑ Culturally Specific Identity (e.g. Two Spirit) ❑ Non-Binary ❑ Questioning ❑ Different Identity ❑ Decline to state ____ **Veteran?** ❑ Yes ❑ No	❑ American Indian/Alaska Native or Indigenous ❑ Asian or Asian American ❑ Black, African American, African ❑ Hispanic/Latina/e/o ❑ Middle Eastern or North African ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Additional Race and Ethnicity Detail	❑ Yes ❑ No	❑ Spouse ❑ Child ❑ Stepchild ❑ Friend ❑ Partner ❑ Grandchild ❑ Other Relative ❑ Other

Name	Date of Birth	Gender	Race/Ethnicity	Disabled?	Relationship to Head of Household
First: ____ Middle: ____ Last: ____	___/___/___ **Social Security** ___-___-___	❑ Female ❑ Male ❑ Transgender ❑ Culturally Specific Identity (e.g. Two Spirit) ❑ Non-Binary ❑ Questioning ❑ Different Identity ❑ Decline to state ____ **Veteran?** ❑ Yes ❑ No	❑ American Indian/Alaska Native or Indigenous ❑ Asian or Asian American ❑ Black, African American, African ❑ Hispanic/Latina/e/o ❑ Middle Eastern or North African ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Additional Race and Ethnicity Detail	❑ Yes ❑ No	❑ Spouse ❑ Child ❑ Stepchild ❑ Friend ❑ Partner ❑ Grandchild ❑ Other Relative ❑ Other

Open Your Heart To HOPE
...preventing homelessness Since 2007 through
HOUSING • OUTREACH • PREVENTION • EDUCATION
www.hopehelps.org

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:**

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Total Household Income:

HOPE's Food Pantry Rules and Regulations

1. HOPE Helps serve 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), and meet with a case manager. The second option allows you to go through the food pantry and choose your items.
3. The pantry is open **Tuesdays & Thursdays from 9:00 AM-11:30 AM AND 12:30-3:30 PM and Wednesdays and Saturdays from 9:00 AM-12:00 PM.** In order to respect our volunteers' time, the pantry ends promptly at closing time. **We cannot serve you in the pantry if you check in less than 10 minutes before closing. We also may have to turn you away and give you a pre-packed bag of food if you are more than 20 minutes early or 20 minutes late.**
4. If a different pantry day/time is needed, clients must **call 321-765-4984 ext 3008** to see what's available. If an alternate time is not available they will receive a pre-packed bag of food.
5. There is **no cell phone use in the pantry**, if you must take a call please step outside and we'll be happy to serve you once you are done with your call.
6. 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.
7. 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. Please request this before you go through the food pantry.
8. Resource staff must be updated with any change in address or number of people living in the household.
9. Any children brought to HOPE's property must be supervised by parents/guardians at all times.
10. **No TOBACCO or other DRUGS of any kind are to be consumed on HOPE's property**. This includes driveway and parking areas.
11. HOPE looks forward to working with you in mutual kindness, dignity, and respect.
12. No animals are allowed in the building unless it is a service dog.
13. **Hold Harmless Agreement**: I/We hereby agree to save and hold harmless HOPE Helps Inc. and 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 assistance, from any liability for the assistance received. 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., and any of its departments, agencies, officers, employees, or relationships.

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 Staff Signature/Date

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

Rev. 2/10/25 DI

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 CoC System Administrators via the CoC HMIS Help Desk by submitting a ticket on our website (https://hmiscfl.org).

1. In order to best serve your needs, to develop meaningful case management plans, to determine your continuing eligibility for services, and to document provision of services, the Continuum of Care (CoC) needs to exchange, share, and/or release data, information or records they may collect about you with other CoC Member Agencies.

2. The information contained in your HMIS records with any Agency is considered confidential and privileged and cannot be exchanged, shared and/or released without your express and informed 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) CoC Member Agencies may not refuse to serve me simply because I do not want my information shared with other service agencies.
   b) Agencies that join the CoC HMIS after I sign this consent/authorization also will have access to the personal information that I authorize for data sharing. All CoC Agencies must make reasonable accommodations to allow me to view the updated list of CoC HMIS Partner Agencies.
   c) 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.
   d) 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.
   e) This release is valid for three years from the date I sign this document. I may revoke this authorization at any time by written request.
   f) Any cancellation of this consent will not retroactively change information that has already been disclosed or actions already taken under your previous authorization.

I give my consent to the exchange of my information, and that of my minor children (if applicable, as listed below), via the CoC 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 Client	**Name and Signature of HOPE Staff**
_____ (Print)	_____ (Print)
_____ (Signature) _____ (Date)	_____ (Signature) _____ (Date)

Minor Children (if any):

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____

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** _____

HOPE Use Only

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"