Client Registration

Date_____

Number of People in Household: _____

Demographic Information for Head of Household

Name	Date of Birth	Veteran?	Sex At Birth	Race/Ethnicity *Select all that apply*	Disabled?	Client's Address
First: _____ Middle: _____ Last: _____	___/___/___ **Social Security** _____-_____-_____ ****Last 4 digits at least****	❑ Yes ❑ No **Primary Language** ❑ English ❑ Spanish ❑ Other _____	❑ Female ❑ Male ❑ Client doesn't know ❑ Client prefers not to answer _____ **Optional**: Pronoun ❑ He/him ❑ She/her ❑ Other _____	❑ American Indian, Alaska Native, or Indigenous ❑ Asian or Asian American ❑ Black, African American or African ❑ Hispanic/Latina/o ❑ Middle Eastern or North African ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Additional Race and Ethnicity Detail _____	❑ Yes ❑ No **Are you receiving food stamps?*** ***Does not impact you receiving food services from HOPE.**** ❑ Yes ❑ No	**Street Address** _____ **Apt.** _____ **City** _____ **Zipcode** _____ **County** _____

Clients Contact Information	Emergency Contact	Relationship to Head Of Household
Client's Phone Number _____ **Client's email** _____	**Name:**_____ **Phone #**:_____	☐ Emergency ☐ Guardian ☐ Mentor ☐ Best Friend ☐ Primary Care Giver ☐ Other ☐ Spouse

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

RV 1/13/26KK

Demographic Information for Additional Household Members

Name	Date of Birth	Sex At Birth	Race/Ethnicity *Select all that apply*	Disabled?	Relationship to Head of Household
First: _____ Middle: _____ Last: _____	____/____/___ **Social Security** ___-_____-_____	❑ Female ❑ Male ❑ Client doesn't know ❑ Client prefers not to answer _____ **Veteran?** ❑ Yes ❑ No	❑ American Indian, Alaska Native, or Indigenous ❑ Asian or Asian American ❑ Black, African American or African ❑ Hispanic/Latina/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. Who? _____ ❑ Other _____

Name	Date of Birth	Sex At Birth	Race/Ethnicity *Select all that apply*	Disabled?	Relationship to Head of Household
First: _____ Middle: _____ Last: _____	____/____/___ **Social Security** ___-_____-_____	❑ Female ❑ Male ❑ Client doesn't know ❑ Client prefers not to answer _____ **Veteran?** ❑ Yes ❑ No	❑ American Indian, Alaska Native, or Indigenous ❑ Asian or Asian American ❑ Black, African American or African ❑ Hispanic/Latina/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. Who? _____ ❑ Other _____

Name	Date of Birth	Sex At Birth	Race/Ethnicity *Select all that apply*	Disabled?	Relationship to Head of Household
First: _____ Middle: _____ Last: _____	____/____/___ **Social Security** ___-_____-_____	❑ Female ❑ Male ❑ Client doesn't know ❑ Client prefers not to answer _____ **Veteran?** ❑ Yes ❑ No	❑ American Indian, Alaska Native, or Indigenous ❑ Asian or Asian American ❑ Black, African American or African ❑ Hispanic/Latina/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. Who? _____ ❑ Other _____

****If there are more household members, please see staff for an additional page***

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

EMERGENCY ASSISTANCE REQUEST

Housing Status	**How long have you been staying there?**
Literally homeless. Where did you stay last night? _____ ☐ Hotel ☐ Staying with a relative ☐ Staying with a friend ☐ Rental with subsidy(Section 8 or low income) ☐ Rental w/o subsidy(No discount) ☐ Owed ☐ Other _____	☐ Less than 7 days ☐ 1 week or more but less than a month ☐ 1 month or more but less than a month ☐ 90 days or more but less than a year ☐ 1 year or longer

State Specific Need	☐ Food ☐ Rent/Mortgage Assistance ☐ Utility Assistance ☐ Hygiene Products ☐Thrift store voucher ☐Financial Counseling ☐Case Management ☐ Other **Please ask Resource Specialist for more information other than food and hygiene.
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:** _____

For Office Use Only

Total Household Income

1/13/26 KK, PG

HOPE's Food Pantry Rules and Regulations

1. HOPE Helps serve Seminole County residents. Our clients may receive food **bi-weekly**. 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. 1/7/26 KK

☐ **Office Staff Only**: Initial once authorized shopper note is entered into HMIS

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: _____