LEVY COUNTY SHIP PROGRAM

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I/We _____, the undersigned, hereby authorize below listed group
(print applicant(s)/household member name)
to release without liability, information regarding my employment, income, and/or assets to Levy County SHIP Program_, for the purposes of verifying information provided as part of determining eligibility for assistance under the Levy County SHIP Program. I understand that only information necessary for determining eligibility can be requested.

Types of Information to be verified:

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/savings accounts, stocks, bonds, certificated of deposits, Individual Retirement Accounts, interest, dividends; payments from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits, unemployment, disability or worker's compensation, welfare assistance, net income from the operation of a business, and alimony or child support payments.

Organizations/Individuals that may be asked to provide written/oral verifications are, but not limited to:

Past/Present Employers
Banks, Financial or Retirement Institutions
State Unemployment Agency
Welfare Agency
Alimony/Child Support Providers
Social Security Administration
Veteran's Administration
Other: _____

Agreement to Conditions:

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

_____

Signature of Applicant Printed Name Date

_____

Signature of Co-Applicant Printed Name Date

_____

Signature of Household Member Printed Name Date

Note: This general consent may not be used to request a copy of a tax return. If one is needed, contact your local IRS office for Form 4506, "Request for Copy of Tax Return" and prepare and sign separately.

THIRD-PARTY VERIFICATION OF PUBLIC ASSISTANCE

Please make copies of this form as needed and fill out one for each person 18 and over.

State and/or Federal Regulations require us to verify employment history and income Information for the person that has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated.

Authorization:

☐ I hereby authorize the release of requested information. A copy of the executed "Authorization for the release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

☐ I **DO NOT** receive public assistance.

Signature of Applicant/Co-Applicant/Household Member	Print Name	Date

Please return information to:

Name: Marlon Gayle Phone: 352-486-5268
Department: Levy County SHIP Program Fax: 352-486-3497
Address: 612 E Hathaway Avenue State: FL Zip: 32621

Agency Name: _____ Contact Person: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

*****APPLICANT: DO NOT WRITE BELOW THIS LINE. FOR OFFICIAL USE ONLY*****

Please provide information about anticipated assistance benefits to be <u>received</u> during the next 12 months: (amount per month)

Number in family: _____

Aid to Families with Dependant Children Cash: $ _____ Foodstamps: $ _____

General Assistance: _____

Other Assistance: _____

Do these amounts include court awarded support payments? ☐ Yes ☐ No

Annual amount of public assistance given the past 12 months: $ _____

Annual amount of public assistance to be awarded for the next 12 months: $ _____

Signature of authorized representative: _____
Print Name: _____ Title: _____
Date: _____ Phone: _____

WARNING: 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 and 775.083.

THIRD-PARTY VERIFICATION OF EMPLOYMENT

Please make copies of this form as needed and fill out one for each person 18 and over.

State and/or Federal Regulations require us to verify employment history and income Information for the person that has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated.

Authorization:

☐ I hereby authorize the release of requested information. A copy of the executed "Authorization for the release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

☐ I **DO NOT** receive employment income. (Unemployed)

Signature of Applicant/Co-Applicant/Household Member _____ Print Name _____ Date _____

Please return information to:

Name: Marlon Gayle Phone: 352-486-5268
Department: Levy County SHIP Program Fax: 352-486-3497
Address: 612 E Hathaway Avenue State: FL Zip: 32621

Employer/Company Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

*****APPLICANT: DO NOT WRITE BELOW THIS LINE. FOR OFFICIAL USE ONLY*****

Please provide information about anticipated employment income during the next 12 months:
Position: _____ Length of Time Employed: _____
Pay Rate: $ _____ Pay Frequency (Hr, Wk, Mo): _____
Average Hours Worked per (Day, Wk, Mo): _____
Overtime Pay Rate: _____ Average Overtime Hours/Wk: _____
Total Annual Base Pay Earnings: $ _____ Total Overtime Base Pay Earnings: $ _____
Amount and Frequency of Other Compensation (bonus, raise, commission, tips): $ _____
Vacation Pay (Y or N): _____ If yes, number of days: _____
Retirement Account (Y or N): _____ Amount Accessible to Employee: $ _____
Total Gross Annual Income, including other compensation, for next 12 months: $ _____ *
Probability & expected date of any pay increase next 12 months not included in figure above*;
Probability: _____ Date: _____ Amount ($, %): _____

Signature of authorized representative: _____
Print Name: _____ Title: _____
Date: _____ Phone: _____

WARNING: 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 and 775.083.

THIRD-PARTY VERIFICATION OF ASSET INCOME

Please make copies of this form as needed and fill out one for each person 18 and over.

State and/or Federal Regulations require us to verify employment history and income Information for the person that has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated.

Authorization:

☐ I hereby authorize the release of requested information. A copy of the executed "Authorization for the release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

☐ I **DO NOT** have any of the below mentioned accounts.

Signature of Applicant/Co-Applicant/Household Member	Print Name	Date

Signature of Applicant/Co-Applicant/Household Member	Print Name	Date

Please return information by mail or fax to:

Name: Marlon Gayle Phone: 352-486-5268
Department: Levy County SHIP Program Fax: 352-486-3497
Address: 612 E Hathaway Ave State: FL Zip Code: 32621

Name of Institution: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

*****APPLICANT: DO NOT WRITE BELOW THIS LINE. FOR OFFICIAL USE ONLY*****

Complete the (applicable) Sections below:

Checking account No.	Average monthly balance for last 6 months	Current interest rate	
Savings account No.	Current Balance	Current interest rate	
Money Market account No	Average monthly balance for last 6 months	Current interest rate	
Certificate of deposit account No.	Amount	Current interest rate	Withdrawal penalty
IRA, Keogh, retirement account No.	Amount	Current interest rate	Withdrawal penalty

Signature of authorized representative: _____
Print Name: _____ Title: _____
Date: _____ Phone: _____

WARNING: 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 and 775.083.

ASSET ADDENDUM TO APPLICATION

In order to properly qualify an applicant for SHIP Assistance, the following asset information for all occupants including minors must be obtained. This information will be used for qualification purposes only.

ASSETS INCLUDE:

Cash held in savings and/or checking accounts, trust funds, equity in real estate and other capital investments, stocks, bonds, Treasury bills, certificates of deposit, money market funds, IRA accounts, retirement and pension funds, lump sum receipts, (i.e. lottery winnings, insurance settlements, etc.), and personal property held as an investment (i.e., gem or coin collections, paintings, antique cars, etc.).

(Do not include necessary personal property such as furniture, automobiles, and clothing.)

(CHECK **ONE** ONLY)

A I (We) hereby state that the combined value of my (our) assets _____ does _____does not exceed $5,000.

TOTAL VALUE OF ASSETS:.....$_____

Or

B. _____ I (We) do not have any assets at this time.

_____ _____
Applicant's Signature Date

_____ _____
Co-Applicant's Signature Date

_____ _____
Household Member's Signature Date