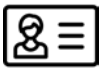
# Workforce Recovery Training Program

## Application Document Checklist

## ☐ Applicant Identification

**(must be a photo ID)**



- Driver License; OR
- State- or Federal-issued ID; OR
- U.S. Passport; OR
- Permanent Resident Card; OR
- Employment Authorization Card

## ☐ Proof of Current Address

- Deed, mortgage, or monthly mortgage statement; OR
- Rental agreement; OR
- Florida vehicle registration or title; OR
- Florida Voter Registration Card; OR
- W-2 Form or 1099; OR
- Utility bill; OR
- Automobile or homeowner's insurance policy or bill; OR
- Medical or health card with address; OR
- Statement from financial institution; OR
- Letter from shelter or half-way house verifying applicant lives at address; OR
- Educational transcripts

## ☐ Proof of Work Authorization

- Social Security Card; OR
- U.S. Birth Certificate; OR
- U.S. Passport; OR
- Permanent Resident Card; OR
- U.S. Citizen Card; OR
- Employment Authorization Card

## ☐ Documentation of Other Forms of Assistance

**(Provide all that apply.)** ***Only if applicable**

- FEMA award letter
- SBA award letter
- Educational assistance award letter
- VOAD, non-profit, or other award letter

## ☐ Income Documentation for All Adult Household Members (18+)

- Most recent tax returns (IRS 1040, 1040A or 1040EZ) signed and submitted; OR
- Documentation of Income:
  - Salary/Wage/Tips: Last 3 months of pay stubs OR signed statement from employer stating wage and frequency of payment.
  - Self-employment Income: IRS 1099, profit/loss statement, or ledger.
  - Interest, Dividends: IRS 1099 DIV or account/holding statements.
  - Benefits: Social security or disability, retirement, SSA, TANF, Veterans', alimony, pension or annuity current letter of benefits (should include benefit amount).
  - Unemployment Income: current letter of benefits or printouts (should include benefit amount).
  - Workers Compensation Income: letter of benefits from insurance company or court (should include benefit amount).
  - Documentation of any other sources of income received regularly.

# Workforce Recovery Training Program

## Application Document Checklist

## ☐ Additional Documentation

**(if applicable)** ***Only if applicable**

- If applicant is disabled, provide one (1) of the following:
  - Social Security Disability Statement
  - Letter from doctor stating applicant qualifies as disabled
  - Verification of Disability Form
- If applicant is a Veteran or active duty spouse or dependent, provide DD Form 214, military identification card, or other recognized documentation.

## ☐ Certifications and Authorizations

- Consent and Release of Personal Information Form
- Fraud Acknowledgement Regarding False or Misleading Statements Certification

## Helpful Information:

- After your initial application is submitted, your application will be reviewed by the program partner(s) you selected. A team member will contact you if any additional documentation is required.
- All information provided to the WRTP will be verified.
- For additional information and updates, visit www.RebuildFlorida.gov.

**Information subject to change. Last revised: July 15, 2020.**

WORKFORCE RECOVERY TRAINING PROGRAM

# APPLICATION FOR ASSISTANCE

**NOTE:** *Only one application should be submitted per person. Duplicative applications will be closed or placed on hold so that only one application per person remains active.*

## SECTION 1 APPLICANT INFORMATION

**APPLICANT**

First Name: * _____ Last Name: * _____ Middle Initial: _____

Current Address: * _____

City: * _____ State: * _____ Zip Code: * _____

Phone #: * _____ Email Address: _____

My preferred method of communication is *(Select one)*:

☐ Phone ☐ Email ☐ Mail

Date of birth (*MM/DD/YYYY*): * ____/____/____

English is my primary language:

☐ Yes ☐ No

If no, what is your primary language *(Select one)*:

☐ Spanish ☐ Creole ☐ Other *(Please specify)*: _____

I am a Veteran or active duty spouse or dependent:

☐ Yes ☐ No

I am authorized to work in the United States: *

☐ Yes ☐ No

Highest level of education completed: *

☐ Some High School ☐ High School Diploma ☐ GED ☐ Vocational Certification

☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree

☐ Other (*Please specify)*: _____



* *Required*

# APPLICATION FOR ASSISTANCE

I request exemption from public records disclosure based on a qualifying exemption category: *

☐ Yes (*additional information may be requested*) ☐ No

If yes, qualifying exemption category must be selected below:

- ☐ Sworn or civilian law enforcement personnel, including correctional and correctional probation officers [§119.071(4)(d)2.a.]
- ☐ Investigator with the Department of Children and Families [§119.071(4)(d)2.a.]
- ☐ Investigation support personnel with the Department of Health [§119.071(4)(d)2.a.]
- ☐ Revenue collection and enforcement or child support enforcement personnel of Department of Revenue or local governments [§ 119.071(4)(d)2.a.]
- ☐ Nonsworn investigative personnel of the Department of Financial Services [§119.071(4)(d)2.b.]
- ☐ Nonsworn investigative personnel of the Office of Financial Regulation's Bureau of Financial Investigations [§119.071(4)(d)2.c.]
- ☐ Firefighter certified in compliance with s. 633.408 [§119.071(4)(d)2.d.] Only currently certified are eligible.
- ☐ Judge or Justice [§119.071(4)(d)2.e.]
- ☐ State attorney, assistant state attorney, statewide prosecutor, or assistant statewide prosecutor [§119.071(4)(d)2.f.]
- ☐ General magistrate, special magistrate, judge of compensation claims, administrative law judge of the Division of Administrative Hearings [§119.071(4)(d)2.g]
- ☐ Code enforcement officer [§119.071(4)(d)2.i.]
- ☐ Guardian ad litem as defined in s. 39.820 [§119.071(4)(d)2.j.]
- ☐ Specified employees of the Department of Juvenile Justice [§119.071(4)(d)2.k.]
- ☐ Public defender, assistant public defender, criminal conflict or civil regional counsel, or assistant criminal conflict or civil regional counsel [§119.071(4)(d)2.l.]
- ☐ Investigator or inspector of the Department of Business and Professional Regulation [§119.071(4)(d)2.m.]
- ☐ County tax collector [§119.071(4)(d)2.n.]
- ☐ Specified personnel of the Department of Health [§119.071(4)(d)2.o.]
- ☐ Impaired practitioner consultants retained by an agency [§119.071(4)(d)2.p.]
- ☐ Emergency medical technicians and paramedics certified under Chapter 401 [§119.071(4)(d)2.q.]
- ☐ Employees in an agency's office of inspector general or internal audit department [§119.071(4)(d)2.r.]
- ☐ Specified addiction treatment facility personnel [§119.071(4)(d)2.s.]
- ☐ Specified child advocacy center personnel [§119.071(4)(d)2.t.]
- ☐ U.S. Attorney, U.S. Judge, U.S. Magistrate [§119.071(5)(i)(1)]*
- ☐ Service members who served after September 11, 2001[§119.071(5)(k)(1)]*
- ☐ Individual in category described in [§119.071(4)(d)2.h.] whose duties include hiring and firing employees, labor contract negotiation, administration, or other personnel-related duties.



* *Required*

# APPLICATION FOR ASSISTANCE

Please check the partner(s) from whom you are interested in receiving training: *

- ☐ CareerSource Brevard – Brevard County
- ☐ The College of the Florida Keys – Monroe County
- ☐ Florida International University – Miami-Dade County
- ☐ Florida State College at Jacksonville – Duval County
- ☐ Hendry County School District – Hendry County
- ☐ Indian River State College – St. Lucie County
- ☐ Valencia College – Orange County and Osceola County
- ☑ Tallahassee State College - Gadsden, Leon, and Wakulla County

Please check the construction trade(s) in which you are interested in receiving training: *

- ☐ Alternative Energy Certification
- ☐ Apartment Maintenance Technician
- ☐ Carpentry
- ☐ Carpet Laying
- ☐ Concrete Finishing
- ☐ Construction
- ☐ Construction Administration Management & Supervision
- ☐ Construction Craft Laborer
- ☐ Construction Workforce Preparation
- ☐ Core Construction
- ☐ Electrical Power Lineman
- ☐ Electricity
- ☐ Glass and Window Installation
- ☐ Heating, Ventilation, and Air Conditioning (HVAC)
- ☐ Heavy Equipment Operations
- ☐ Industrial Mechanics
- ☐ Masonry
- ☐ Painting
- ☐ Plastering
- ☐ Plumbing
- ☐ Roofing
- ☐ Solar Panel Technician
- ☐ Solar Thermal Technician
- ☐ Solar Photovoltaic Installation
- ☐ Sprinkler Fitting
- ☐ Welding

☑ Other *(Please Specify):* Drone Training

*Note: Individualized programs may not be available from all partners.*



* *Required*

# APPLICATION FOR ASSISTANCE

*Only if applicable

## APPLICANT COMMUNICATION DESIGNEE

Applicants to the Rebuild Florida Workforce Recovery Training Program (WRTP) can designate a third party to obtain information about their program application. This third party is known as the Communication Designee and they will be authorized to make inquiries of the applicant's program status either in person, via the phone, email and/or mail. The person designated as the Communication Designee **is not authorized to sign** the Grant Agreement or any other documents or Affidavits on behalf of the applicant unless they also hold a valid Power of Attorney. The person designated as the Communication Designee **is not authorized to make any decision** on behalf of the applicant unless they also hold a valid Power of Attorney. You may designate an individual or a representative at an agency as your Communication Designee.

First Name: _____ Last Name: _____ Middle Initial: _____

Relationship *(Select one)*: ☐ Family Member ☐ Friend ☐ Other *(Please specify)*: _____

Agency Name *(If applicable):* _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email Address: _____



* *Required*

## SECTION 2 HOUSEHOLD INFORMATION

*Information provided in this section of the application must include **all** members of the household residing at the applicant's current address, regardless of age.*

### HOUSEHOLD COMPOSITION

Fill out the chart below listing all members of the household residing at the applicant's current address **starting with the name of the Head of Household**.

| Name | Age | Male / Female | Relationship to Head of Household | Estimated Total Monthly Income (*see information below)* | Race (enter number from 1-11, *see instructions below)* | Ethnicity (enter number from 1-3, *see instructions below)* |
|---|---|---|---|---|---|---|
| | | | **Head of Household *** | $ | | |
| | | | | $ | | |
| | | | | $ | | |
| | | | | $ | | |
| | | | | $ | | |
| | | | | $ | | |
| | | | | $ | | |
| | | | | $ | | |
| | | | Fill in Total **TOTAL** | $ | | |

### TOTAL HOUSEHOLD INCOME

$_____ Estimated Total Annual Household income * Fill in Total

Household income should be calculated as the total income of all members of the household. The monthly income provided above may be used to assist in calculation of estimated total annual household income.



* *Required*

**USE THE FOLLOWING INFORMATION TO ASSIST IN COMPLETING THE CHART ON PREVIOUS PAGE:**

**Income**
Income should include:

- Wages, salaries, tips, commissions, etc.;
- Self-employment income from own nonfarm business, including proprietorships and partnerships;
- Farm self-employment income;
- Interest, dividends, net rental income, or income from estates or trusts;
- Social Security or railroad retirement;
- Supplemental Security Income, Aid to Families with Dependent Children, or other public assistance or public welfare programs;
- Retirement, survivor, or disability pensions; and
- Any other sources of income received regularly, including Veterans' (VA) payments, unemployment compensation, and alimony.

*Race and ethnicity information is being collected to ensure compliance with federal Fair Housing and Equal Opportunity regulations. This information is not to be used for screening purposes. Providing this information is optional. Should you wish not to provide this information, please mark "Decline to Report."*

**Race**
Enter the appropriate number from the list below:

1. American Indian/Alaskan Native
2. American Indian/Alaskan Native & Black/African American
3. American Indian/Alaskan Native & White
4. Asian
5. Asian & White
6. Black/African American
7. Black/African American & White
8. Native Hawaiian/Pacific Islander
9. Other Multi-Racial
10. White
11. Decline to report

**Ethnicity**
Enter the appropriate number from the list below:

1. Hispanic
2. Non-Hispanic
3. Decline to report



* *Required*

If Applicable

## SECTION 3 DUPLICATION OF BENEFITS (DOB)

*Use this section to disclose all forms of assistance provided for damage or recovery resulting from Hurricane Irma (September 10, 2017). Information must be complete and as accurate as possible. The Rebuild Florida program will verify all information. It is important that the names and addresses of all providers are accurate in order to complete the application process. Your application may not be processed if the information provided cannot be verified.*

***Warning**: Any person who knowingly makes a false claim or statement to the State of Florida may be subject to civil or criminal penalties under 18 U.S.C. 287, 1001 and 31 U.S.C. 3729.*

Has assistance ever been provided to the applicant related to Hurricane Irma? Assistance includes **money, loans, grants, scholarships, volunteer labor, materials, or other assistance provided related to damage or disaster recovery, including economic recovery.** *

☐ Yes ☐ No

### FEDERAL EMERGENCY MANAGEMENT AGENCY – INDIVIDUAL ASSISTANCE (FEMA-IA)

Did you register for **Federal Emergency Management Agency - Individual Assistance (FEMA-IA)** assistance? *

☐ Yes ☐ No

If yes, list **FEMA-IA** Registration ID Number: _____

If yes, was **FEMA-IA** assistance approved for the damaged property?

☐ Yes ☐ No

If yes, please attach a copy of your **FEMA-IA** registration and/or benefits letter.

Amount of **FEMA-IA** approved: $ _____

Amount of **FEMA-IA** provided to-date: $ _____

List any outstanding balance: $ _____

If yes, what year(s) was this assistance received? _____

If yes, describe the purpose of assistance received (repairs, housing stipends, business assistance, etc.):

_____

_____

If yes, was **FEMA-IA** assistance used for costs relating to workforce training or educational tuition/fees/supplies?

☐ Yes ☐ No



* *Required*

# APPLICATION FOR ASSISTANCE

If Applicable

## U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)

Did you register for **U.S. Department of Housing and Urban Development (HUD)** assistance? *

☐ Yes ☐ No

If yes, what year(s) was this assistance received? _____

If yes, describe the purpose of assistance received (repairs, housing stipends, business assistance, etc.):

_____

_____

If yes, was **HUD** assistance used for costs relating to workforce training or educational tuition/fees/supplies?

☐ Yes ☐ No

## U.S. DEPARTMENT OF AGRICULTURE (USDA)

Did you register for **U.S. Department of Agriculture (USDA)** assistance? *

☐ Yes ☐ No

If yes, what year(s) was this assistance received? _____

If yes, describe the purpose of assistance received (repairs, housing stipends, business assistance, etc.):

_____

_____

If yes, was **USDA** assistance used for costs relating to workforce training or educational tuition/fees/supplies?

☐ Yes ☐ No

## SMALL BUSINESS ADMINISTRATION (SBA)

Did you apply for a **Small Business Administration (SBA)** Disaster Assistance Loan? *

☐ Yes ☐ No

If yes, list **SBA** ID/Application number: _____

If yes, was the **SBA** loan approved?

☐ Yes ☐ No

If yes, please attach a copy of your **SBA** Disaster Assistance Loan approval letter.



* *Required*

# APPLICATION FOR ASSISTANCE

If Applicable

| | |
|---|---|
| Amount of the **SBA** Disaster Assistance Loan approved: | $ _____ |
| Amount of **SBA** Disaster Assistance Loan provided to-date: | $ _____ |
| List any outstanding balance: | $ _____ |

If yes, what year(s) was this assistance received? _____

If yes, describe the purpose of assistance received (repairs, housing stipends, business assistance, etc.):

_____

_____

If yes, was **SBA** assistance used for costs relating to workforce training or educational tuition/fees/supplies?

☐ Yes ☐ No

If yes, and you did not receive assistance, did you decline assistance?

☐ Yes ☐ No

If you declined assistance:

| | |
|---|---|
| What was the amount of the loan? | $ _____ |
| Why did you decline the loan? | ☐ Loss of Employment<br>☐ Reduction in Income<br>☐ Over 30% of gross income spent on housing<br>☐ Substantial increase in debt since **SBA** Disaster Assistance Loan qualification<br>☐ Other: _____ |



* *Required*

# APPLICATION FOR ASSISTANCE

If Applicable

## EDUCATIONAL ASSISTANCE

Have you received any assistance relating to workforce training or educational tuition/fees/supplies from an **educational institution, technical center, federal- or state-funded program, non-profit, or other entity**? *

☐ Yes ☐ No

If yes, list all entities that have provided assistance to the applicant and the amount/estimated amount of assistance:

| **Name of Entity** | **Contact Name** | **Contact Phone Number** | **Type of Assistance** *(Scholarship or Grant or Other)* | **Amount of Assistance** |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | **TOTAL** | $ |



* *Required*

# APPLICATION FOR ASSISTANCE

If Applicable

## OTHER

Have you received any additional assistance from a **Voluntary Organization Active in Disaster (VOAD), non-profit or other type of local organization**? *

☐ Yes ☐ No

If yes, list all organizations that have provided assistance to the applicant and the amount/estimated amount of assistance:

| **Name of Organization** | **Contact Name** | **Contact Phone Number** | **Type of Assistance** *(Money/Gift Card/ Voucher or Volunteer Labor/Materials or Other)* | **Amount of Assistance or Estimated Value of Labor/Materials** |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | **TOTAL** | $ |



* *Required*

## SECTION 4 DOCUMENTATION REQUIREMENTS

*In order for the WRTP application to be complete, the following documents must be submitted to the Program.*

**DOCUMENT CHECKLIST**

- ☒ Applicant Identification
- ☒ Proof of Current Address
- ☒ Proof of Work Authorization
- ☐ Documentation of all other forms of assistance (e.g. FEMA, SBA, workforce training, educational, VOAD, etc.)
- ☒ Proof of Income for all adult (18 and over) household members
- ☒ Consent and Release of Personal Information Form
- ☒ Fraud Acknowledgement Regarding False or Misleading Statements Certification
- ☐ If applicable, Verification of Disability Form
- ☐ If applicable, Proof of status as a Veteran or active duty spouse or dependent

Forms listed above are available at rebuildflorida.gov. Please download and complete all applicable forms.

Completed forms and other required documentation should be submitted with the completed WRTP application. A program partner may contact you if any required documentation is incomplete or further documentation is required.



* *Required*

## SECTION 5 APPLICANT OR AUTHORIZED REPRESENTATIVE CERTIFICATION

*The applicant or authorized representative must read and sign the following certification.*

### NOTICES

**WARNING:** Any person who knowingly makes a false claim or statement to HUD may be subject to civil or criminal penalties under 18 U.S.C. 287, 1001 and 31 U.S.C. 3729.

**Notice of Electronic Capture and Storage of Data:** Electronic records will be collected and maintained by the REBUILD FLORIDA program and its subrecipients related to you and your household in order to process your application. This data will be maintained electronically in secured databases. Verifications of portions of the information you provide, or we obtain about you or your household may be conducted via automated systems.

**Release of Information:** Your signature and the signature of each of your household members who is 18 years of age or older is required on the Consent and Release of Personal Information Form. The release authorizes the REBUILD FLORIDA program and its subrecipients to obtain information from a third party related to your continued participation in the program.

### APPLICANT/AUTHORIZED REPRESENTATIVE CERTIFICATIONS

By submitting this application, I certify that to the best of my knowledge and belief, all information on or attached to this application is true, correct, and complete as of the date the application is submitted. I acknowledge that I am submitting this application in good faith. I acknowledge that any intentional or negligent misrepresentation contained in this application may result in civil liability, including monetary damages, to any person who may suffer any loss due to reliance upon any misrepresentation made on this application. Additional penalties may include criminal penalties, including, but not limited to, fine, imprisonment or both. Any false or fraudulent information provided on this application or in support of the application may be grounds for the program to terminate my application, deny eligibility, or require repayment of all or a portion of funds to the REBUILD FLORIDA program. I understand that any information I provide may be investigated.

_____

Applicant Printed Name *

_____ _____

Applicant Signature * Date *

The **Florida Department of Economic Opportunity (DEO)** does not discriminate on the basis of race, color, national origin, sex, age, religion, disability, or familial status and provides, upon request, reasonable accommodation, including auxiliary aids and services, to afford an individual with a disability an equal opportunity to participate in all services, programs and activities. Towards this end, we continually strive to make our web platform friendly to screen readers and other accessibility-related software and provide accessible documents where possible. Any person requiring assistance, including language interpretations or copies of a specific document, should contact a WRTP program partner using the contact information provided at www.RebuildFlorida.gov. Text Telephone (TTY) callers please use the 711 relay.

**Program funded by the U.S. Department of Housing & Urban Development**



* *Required*

## FRAUD ACKNOWLEDGEMENT REGARDING FALSE OR MISLEADING STATEMENTS

| | |
|---|---|
| Applicant Name | County |
| Address | City, State Zip Code |
| Phone | Email |

a) NOTICE: Applicant is hereby notified that intentionally or knowingly making a materially false or misleading statement relating to the Program could result in ineligibility for benefits, action to recover any Program benefits paid to or on behalf of Applicant, and/or a referral to criminal law enforcement.

b) Applicant represents that all statements and representations made by Applicant regarding any other disaster recovery funding received by Applicant have been and shall be true and correct.

c) Applicant hereby represents that the Applicant has received, read, and understands this notice of penalties for making a materially false or misleading statement to obtain Program benefits.

d) In any proceeding to enforce this grant agreement, the State shall be entitled to recover all costs of enforcement, including actual attorney's fees.

Applicant Signature

Applicant Printed Name

Date

**Rebuild Florida Workforce Recovery Training Program**
**Subrogation Agreement**

Federal law prohibits any person, business concern, or other entity from receiving Federal funds for any part of such loss as to which he has received financial assistance under any other program, or from insurance or any other source. A duplication of benefits ("DOB") occurs when a beneficiary receives assistance, the assistance is from multiple sources, and the assistance amount exceeds the need for a particular recovery purpose. The DOB prohibition applies to federally funded programs providing financial assistance as a result of a major disaster or emergency.

To comply with federal law, the undersigned Recipient(s) of benefits under the Rebuild Florida Workforce Recovery Training Program (the "Program") being administered by the Florida Department of Economic Opportunity ("DEO"), the Recipient(s) hereby assigns to DEO all of his and/or her future rights to reimbursement and all payments that may be received, or have been previously received and not disclosed, under any Federal Emergency Management Agency ("FEMA") program, Small Business Administration ("SBA") program, Department of Labor ("DOL") program, nonprofit donations or grants, or any other funding, or from claims or causes of action Recipient may have ("Proceeds" or DOB) relating to job training, support services, job readiness, or other benefits provided through the Program relating to the disaster or emergency for which these CDBG-DR funds are awarded.

The DEO's rights under this Agreement regarding Proceeds or DOB shall be subject to the following:

A. If Proceeds are received by the Recipient(s) between the date of this Agreement and the date of completion of Program participation, then the Recipient(s) must repay DEO the difference between (i) the total amount of Program disbursements as of the date the Proceeds were received, and (ii) the total amount that would have been made if such Proceeds had been included in the original DOB calculation.

B. If Proceeds are received by the Recipient after the date of completion of Program participation, then the Recipient(s) must turn over to DEO the total amount of the Proceeds up to, but not exceeding, the amount received under Program benefits.

The Recipient(s) agree to assist and cooperate with DEO should DEO elect to pursue any of the claims the Recipient has or may have for benefits or reimbursement under any Federal, State, or private sources. The Recipient(s)'s assistance and cooperation shall include allowing suit to be brought in the name(s) of the Recipient(s), giving depositions, providing documents, producing records and other evidence, testifying at trial, and any other form of assistance and cooperation reasonably requested by DEO.

If requested by DEO, the Recipient(s) agree to execute such further and additional documents and instruments as may be requested to further and better assign to DEO the Proceeds and/or any rights thereunder as contemplated by this Agreement, and to take, or cause to be taken, all actions and to do, or cause to be done, all things requested by DEO to consummate and make effective the purposes of this Agreement.

The Recipient(s) explicitly allows DEO to request of any company or entity with which the Recipient held policies, or FEMA, or the SBA, or any other entity from which the Recipient(s) has applied for or is receiving Proceeds, any non-public or confidential information determined to be reasonably necessary by DEO to monitor and/or enforce its interest in the rights assigned to it under this Agreement and gives the Recipient(s)'s consent to such company or entity to release said information to DEO.

The Recipient(s) agrees that any lawyer or claims adjuster representing the Recipients in connection with Program benefits or services are authorized and instructed to communicate with DEO regarding the nature and status of claims and to share information with DEO relating to the claims. The lawyer and claims professional shall protect the interest of the State in any proceeds resulting from the claim upon receipt of notice of this subrogation.

If the Recipient(s) hereafter receives any Proceeds for the same purpose as the Program, the Recipient(s) agree to promptly pay such Proceeds, or an equivalent amount of funds, to DEO in accordance with the terms of this Agreement.

In any proceeding to enforce this Agreement, DEO shall be entitled to recover all costs of enforcement, including actual attorneys' fees.

| *Printed Name* | *Signature* | *Date* |
|---|---|---|

| *Printed Name* | *Signature* | *Date* |
|---|---|---|

**STAFF VERIFICATION**

I certify that the individual(s) whose signature appears above provided the information recorded on this form.

| *Printed Name* | *Signature* | *Date* |
|---|---|---|

## CONSENT AND RELEASE OF PERSONAL INFORMATION

| | |
|---|---|
| Applicant Name | County |
| Address | City, State Zip Code |
| Phone | Email |

Applicant acknowledges that previous or current personal information may be necessary to process Applicant's Workforce Recovery Training Program application. Verifications and inquiries that may be requested include, but are not limited to: personal identity, insurance claim information, bank and financial records, tax returns, employment, property records, income and assets. Applicant hereby consents and authorizes the Rebuild Florida Program, its agents, contractors and assigns to request, access, review, disclose, release and share personal information – including any private or confidential information which is not subject to public disclosure but is necessary to process the application. Applicant further acknowledges that any party disclosing information to Rebuild Florida is not responsible for any negligent misrepresentation or omission, and Applicant agrees to hold such parties harmless from and against all claims, actions, suits or other proceedings, and any and all losses, judgments, damages, expenses or other costs (including reasonable attorneys' fees and disbursements), arising from or in any way relating to their disclosure. Applicant further acknowledges that the information gathered may be released to any other governing agency responsible for auditing Rebuild Florida including, but not limited to the Department of Housing and Urban Development (HUD) or the Office of Inspector General (OIG). This form will remain valid until revoked in writing.

### PRIVACY POLICY

The Applicant acknowledges that he/she has received and reviewed the Rebuild Florida's privacy policy as it relates to the Applicant's personal information and the Applicant's right to privacy. Rebuild Florida's ability to access the Applicant's personal information is a condition of participation in Program.

Applicant Signature

Applicant Printed Name

Date

# Income Self-Attestation Form

The Rebuild Florida Workforce Recovery Training Program (Program) requires that income sources be verified and documented. Complete the information below only if you have no other way to document your income. Upon completion, submit this form to the appropriate subrecipient. **If you do not have any income sources, do NOT complete this form. You must complete the Zero-Income Certification Form. Check with the appropriate program partner to receive the correct form.**

I, _____, have applied for or am a part of the household that applied for assistance under the Program. I understand that Program regulations require verification of all income sources from household members 18 years of age or older.

| **JUSTIFICATION FOR SELF-ATTESTATION**<br>*Please check all that apply** | |
|---|---|
| ☐ I get paid in cash. | ☐ I do not get pay stubs. |
| ☐ I do not get pay checks. | ☐ I cannot get a letter from my employer. |

| **INCOME INFORMATION** | | | |
|---|---|---|---|
| Cash income | $ | How often (weekly, monthly, etc.) | |
| Employer | | | |
| Employer Address | | | |

I certify that I have no other way to document my income. I understand that any misrepresentation of information or failure to disclose information requested on this form could disqualify the household from being eligible for the Program. I also understand that this self-attestation may be subject to further verification by the U.S. Department of Housing & Urban Development, the Program or any other State or Federal agency. I, therefore, authorize such verification, and I will provide supporting documents, if necessary. **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 U.S. Government.

I certify that the above information is true and correct.

*Check One:*

☐ **PARTICIPANT APPLICANT** ☐ **HOUSEHOLD MEMBER**

| *Printed Name* | *Signature* | *Date* |
|---|---|---|

## STAFF VERIFICATION

I certify that the individual whose signature appears above provided the information recorded on this form.

| *Printed Name* | *Signature* | *Date* |
|---|---|---|

# VERIFICATION OF DISABILITY FORM

| | |
|---|---|
| Applicant Name | County |
| Address | City, State Zip Code |
| Phone | Email |

The Applicant is seeking assistance in the Rebuild Florida Workforce Recovery Training Program (Program). The Program utilizes the US Department of Housing and Urban Development (HUD) definitions of "elderly" and / or federal definitions of "disability". See Page 2 for acceptable definitions of "disability".

An individual claiming a disability may prove their disability status using one of three methods: 1) presentation of a mobility card, 2) presentation of proof of SSDI benefits, or 3) presentation of a Disability Verification Form. The Applicant named above asserts that he/she has a disability which may require accommodations to Program Assistance.

**INSTRUCTIONS**: This section must be completed by a professional licensed by the state to diagnose and treat the disability. Acceptable qualified sources include: physicians, state licensed psychologists or psychiatrists. All information provided by a licensed state professional will be used solely to establish disability status. Program administration may not ask about the nature of an individual's disability, and the licensed state professional should not disclose specific details of any disability or diagnosis.

VERIFICATION OF DISABILITY:

It is my professional opinion that the above-named individual asserting disability **DOES / DOES NOT** meet the definition of disability set forth in this Verification. *(Please circle application option)*

| | |
|---|---|
| Name & Title of Licensed Professional | Agency/Organization |
| Professional License/Credentials Number | Address |
| Phone Number | City, State, ZIP Code |
| Signature of Licensed Professional | Date |

An applicant or person asserting disability must meet the definition of disability, person with a disability, handicapped person, or disabled/incapacitated person contained in one or more of the following laws:

I. **The Social Security Act, as amended 42 U.S.C. § 423(d)(1) and (3)**
   a. The term "disability" means—
      i. Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or
      ii. In the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 416(i)(1) of this title), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.
   b. For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

II. **The Americans With Disabilities Act of 1990, as amended, 42 U.S.C. §§ 12102(1)-(3)**
   a. Disability The term "disability" means, with respect to an individual—
      i. A physical or mental impairment that substantially limits one or more major life activities of such individual;
      ii. A record of such an impairment; or
      iii. Being regarded as having such an impairment (as described in paragraph (c)).
   b. Major life activities
      i. In general For purposes of paragraph (1), major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.
      ii. Major bodily functions For purposes of paragraph (1), a major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.
   c. Regarded as having such an impairment For purposes of paragraph (II)(a)(iii):
      i. An individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.
      ii. Paragraph (II)(a)(iii) shall not apply to impairments that are transitory and minor. A transitory impairment is an impairment with an actual or expected duration of 6 months or less.

III. **United States Department of Housing and Urban Development (HUD) regulations, 24 CFR §§ 5.403 and 891.505**
   a. Disabled family means a family whose head (including co-head), spouse, or sole member is a person with a disability. It may include two or more persons with disabilities living together, or one or more persons with disabilities living with one or more live-in aides.

b. Person with disabilities:
    i. Means a person who:
        1. Has a disability, as defined in 42 U.S.C. 423;
        2. Is determined, pursuant to HUD regulations, to have a physical, mental, or emotional impairment that:
            a. Is expected to be of long-continued and indefinite duration;
            b. Substantially impedes his or her ability to live independently, and
            c. Is of such a nature that the ability to live independently could be improved by more suitable housing conditions; or
        3. Has a developmental disability as defined in 42 U.S.C. 6001.
    ii. Does not exclude persons who have the disease of acquired immunodeficiency syndrome or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome;
    iii. For purposes of qualifying for low-income housing, does not include a person whose disability is based solely on any drug or alcohol dependence; and
    iv. Means "individual with handicaps", as defined in § 8.3 of this title, for purposes of reasonable accommodation and program accessibility for persons with disabilities.

**891.505**

*Handicapped family* means:

I. Families of two or more persons the head of which (or his or her spouse) is handicapped;
II. The surviving member or members of any family described in paragraph (1) of this definition living in a unit assisted under subpart E of this part with the deceased member of the family at the time of his or her death;
III. A single handicapped person over the age of 18; or
IV. Two or more handicapped persons living together, or one or more such persons living with another person who is determined by HUD, based upon a licensed physician's certificate provided by the family, to be essential to their care or well being.

*Handicapped person* or *individual* means:

I. Any adult having a physical, mental, or emotional impairment that is expected to be of long continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions.
II. A person with a developmental disability, as defined in section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act ( 42 U.S.C. 6001(5), i.e., a person with a severe chronic disability that:
    a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
    b. Is manifested before the person attains age twenty-two;
    c. Is likely to continue indefinitely;
    d. Results in substantial functional limitation in three or more of the following areas of major life activity:
        i. Self-care;
        ii. Receptive and expressive language;
        iii. Learning;
        iv. Mobility;
        v. Self-direction;
        vi. Capacity for independent living;
        vii. Economic self-sufficiency; and

e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

This definition covers individuals with acquired immunodeficiency syndrome or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome. It DOES NOT include conditions based solely on any drug or alcohol dependence.

# Zero Income Self-Attestation Form

The Rebuild Florida Workforce Recovery Training Program (Program) requires that income sources be verified and documented. Complete the information below only if you have no source(s) of income. Upon completion, submit this form to the appropriate subrecipient. **If you have any income sources, do NOT complete this form. You must complete the Income Self-Attestation Form. Check with the appropriate program partner to receive the correct form.**

I, _____, have applied for or am a part of the household that applied for assistance under the Program. I understand that Program regulations require verification of all income sources from household members 18 years of age or older. I am aware that income includes, but it not limited to:

- Wages, salaries, overtime pay, commissions, fees, tips and bonuses;
- Self-employment income from operation of a business, including proprietorships and partnerships;
- Farm income;
- Net rental income;
- Interest, dividends, or income from estates or trusts;
- Social Security or railroad retirement;
- Supplemental Security Income, Aid to Families with Dependent Children, or other public assistance or public welfare programs;
- Retirement, survivor, or disability pensions;
- Veterans' (VA) payments;
- Payment in lieu of earnings, such as unemployment compensation, reemployment assistance, disability compensation, worker's compensation, and severance pay;
- Alimony (or separate maintenance payments);
- Periodic payments received from annuities, insurance policies, retirement funds, disability, or death benefits (except insurance proceeds received as a result of someone's death) and other similar types of periodic receipts;
- Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609(b)(5));
- Regular pay, special pay, and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling);
- Regular monetary gifts from family and/or friends; and
- Other income, including prizes and awards; gambling, lottery or raffle winnings; jury duty fees.

I have stated during this verification process that I have no income at this time. I understand that any misrepresentation of information or failure to disclose information requested on this form could disqualify the household from being eligible for the Program. I also understand that this certification statement may be subject to further verification by the U.S. Department of Housing & Urban Development, the Program or any other State or Federal agency. I, therefore, authorize such verification, and I will provide supporting documents, if necessary.

**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 U.S. Government.

I certify that the above information is true and correct.

*Check One:*

☐ **PARTICIPANT APPLICANT** ☐ **HOUSEHOLD MEMBER**

| _____ | _____ | _____ |
|---|---|---|
| *Printed Name* | *Signature* | *Date* |

**STAFF VERIFICATION**

I certify that the individual whose signature appears above provided the information recorded on this form.

| _____ | _____ | _____ |
|---|---|---|
| *Printed Name* | *Signature* | *Date* |