

## CDBG MOBILITY RAMP APPLICATION

APPLICANT'S NAME: \_\_\_\_\_ SS# \_\_\_\_\_

CO-APPLICANT'S NAME: \_\_\_\_\_ SS# \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALTERNATIVE PHONE: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Check ONE:**

**Marital Status:**    \_\_\_ Single    \_\_\_ Married    \_\_\_ Separated    \_\_\_ Divorced    \_\_\_ Widow

**QUESTIONS:**

Name of the household member needing the ramp: \_\_\_\_\_

Are you a Veteran?     YES     NO

If YES, have you ever applied for a Mobility Ramp with the VA?     YES     NO

Do you rent or own your mobile home?     RENT     OWN

Do you rent or own the land that your mobile home is on?     RENT     OWN

Do you have a mortgage on your mobile home?     YES     NO    Monthly payment: \$ \_\_\_\_\_

**ANNUAL INCOME - Please list all household annual (YEARLY) income.**

**\*\* Note: Please use GROSS income not net income\*\***

SOURCE	APPLICANT	CO-APPLICANT	OTHER MEMBER	TOTAL
Gross Salary				
Overtime, Tips, etc.				
Interest/Dividends				
Business Net Income				
Rental Net Income				
Social Security, Pensions, etc.				
Unemployment, Workers Comp				
Alimony, Child Support				
Welfare Payments				
Other				



**ASSETS**

TYPE	CASH VALUE	ANNUAL INCOME FROM ASSETS	BANK NAME	ACCOUNT NO.
Checking Accounts:				
Savings Accounts:				
Credit Union Accounts:				
Stocks, Life Insurance:				

**DECLARATION:** I am applying for a Community Development Block Grant to pay for a semi-portable Mobility Ramp. The information on this form is to be used to determine household income for eligibility. I have provided, for each person set forth on Page 2, acceptable verification of current and anticipated annual income. I certify that the statements are true and complete to the best of my knowledge and belief and are given under penalty of perjury.

**WARNING:** Florida Statute 817 provides that willful false statements or misrepresentation concerning income and assets relating to financial condition is a misdemeanor of the first degree and is punishable by fines and imprisonment provided under S775.082 ro 775.93.

\_\_\_\_\_  
 APPLICANT

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 CO-APPLICANT

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 HOUSEHOLD MEMBER (18 years old or older)

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 HOUSEHOLD MEMBER (18 years old or older)

\_\_\_\_\_  
 DATE



**MARION COUNTY**  
**Board of County Commissioners**  
**Community Services**  
3003 SW College Road, Suite 109  
Ocala, Florida 34474  
(352) 671-8770 – Fax (352) 671-8769

## **CDBG AUTHORITY TO VERIFY INFORMATION**

This is your authority to verify my bank accounts, employment, medical need, and to make any other inquires pertaining to my eligibility for assistance. You may make copies of this letter for distribution to any party with which I have a financial / medical relationship and that party may treat such copy as an original.

Privacy Act Notice: This information is to be used by the agency collecting it or its assignees in determining whether you qualify for assistance under its program. It will not be disclosed outside the agency except as required and permitted by law. You do not have to provide this information, but if you do not your application for approval as a prospective program recipient may be delayed or rejected.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Applicant

\_\_\_\_\_  
Date



**REQUEST FOR VERIFICATION OF DEPOSIT**

**Privacy Act Notice:** This information is to be used by the agency collecting it or its assignees in determining whether you qualify as a prospective mortgagor under its program. It will not be disclosed outside the agency except as required and permitted by law. You do not have to provide this information, but if you do not your application for approval as a prospective mortgagor or borrower may be delayed or rejected. The information requested in this form is authorized by Title 38USC, Chapter 37 (if VA); by 12 USC, Section 1701, et.seq. (If HUD/FHA); BY 42 USC, Section 1452b (if HUD/CPD); and Title 42 USC, 1471 et.seq. Or 7 USC, 1921 et seq. (If USDA/FmHA).

**Part I - Applicant Instructions: COMPLETE ITEMS 1, 7, 8, AND 9.**

1. To (Name and COMPLETE Mailing Address of depository/bank)	2. From: Marion County Community Services 3003 SW College Road, Suite 109 Ocala, FL 34474
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I certify that this verification was sent directly to the bank/depository and has not passed through the hands of the applicant or any other party.

3. Lender Signature	4. Title CDBG Staff	5. Date	6. Lender Phone Number (352) 671-8770
7. Information to be Verified			
Type of Account	In Name(s)	Account Number	Estimated Balance

**To Depository:** I/We have applied for a mortgage loan and stated in my financial statement that the balance on deposit with you is shown above. You are authorized to verify this information and to supply the lender identified above with the information requested in items 10 through 13. Your response is solely a matter of courtesy which no responsibility is attached to your institution or any of your officers.

8. Name and address of Applicant(s)	9. Signature of Applicant(s)

**❖ APPLICANT - DO NOT SUBMIT THIS FORM TO YOUR DEPOSITORY/BANK. WE ARE REQUIRED TO MAIL IT DIRECTLY TO THEM FOR COMPLETION.**

**Part II - Verification of Depository (To be completed by Depository)**

10. Deposit Accounts

Type Account	Account Number	Current Balance	Withdrawal Fee	Avg. 6 Month Balance	Rate/Interest Income YTD	Date Opened

11. Loans Outstanding

Loan Number	Date of Loan	Original Amount	Current Balance	Mo. Installment	Secured by	Number Late Payments

12. Additional information which may be of assistance in determination of credit worthiness, including loans paid-in-full.

**13. If the name(s) on the accounts differ from those listed in Item 7, please supply the name(s) on the account(s) as reflected in your records.**

**Part III - Authorized Signature** - Federal statutes provide severe penalties for any fraud, intentional misrepresentation, or criminal connivance or conspiracy purposed to influence the issuance or any guaranty or insurance by the VA secretary, the U.S.D.A., FmHA/FHA Commissioner, or the Hud/CPD Assistant Secretary.

14. Signature of Depository Representative	15. Title (Please print or type)
16. Please print or type name signed in Item 14.	17. Phone Number
	18. Date



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**Section I - To be completed by Applicant and returned to Community Services.**

EMPLOYER NAME: \_\_\_\_\_

EMPLOYER MAILING ADDRESS: \_\_\_\_\_

APPLICANT NAME: (Print) \_\_\_\_\_ S.S. #: \_\_\_\_\_

I hereby grant permission and authorize my employer to disclose full information as to my anticipated annual income to the Marion County Community Services Department where I have applied for assistance.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**\* APPLICANT - DO NOT SUBMIT THIS FORM TO YOUR EMPLOYER. WE ARE REQUIRED TO MAIL IT DIRECTLY TO THEM FOR COMPLETION.**

**Section II - To be completed by Employer and returned to Community Services.**

Hire Date: \_\_\_\_\_ Position: \_\_\_\_\_

**Please complete ONE of the following:**

- |               |          |             |          |
|---------------|----------|-------------|----------|
| 1. Hourly     | \$ _____ | 4. Weekly   | \$ _____ |
| 2. Bi-Weekly  | \$ _____ | 5. Monthly  | \$ _____ |
| 3. Bi-Monthly | \$ _____ | 6. Annually | \$ _____ |

Average hours worked per week: \_\_\_\_\_ Weeks worked per year: \_\_\_\_\_

Vacation Pay (Y or N): \_\_\_\_\_ Number of days: \_\_\_\_\_

**ANTICIPATED** additional ANNUAL INCOME from:

- |            |          |                |          |
|------------|----------|----------------|----------|
| 1. Tips    | \$ _____ | 3. Commissions | \$ _____ |
| 2. Bonuses | \$ _____ | 4. Overtime    | \$ _____ |

Has employee been terminated? \_\_\_\_\_ If yes, is the individual eligible for unemployment benefits? \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**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 or 775.83



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**Section I - To be completed by Applicant and returned to Community Services.**

EMPLOYER NAME: \_\_\_\_\_

EMPLOYER MAILING ADDRESS: \_\_\_\_\_

APPLICANT NAME: (Print) \_\_\_\_\_ S.S. #: \_\_\_\_\_

I hereby grant permission and authorize my employer to disclose full information as to my anticipated annual income to the Marion County Community Services Department where I have applied for assistance.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**\* APPLICANT - DO NOT SUBMIT THIS FORM TO YOUR EMPLOYER. WE ARE REQUIRED TO MAIL IT DIRECTLY TO THEM FOR COMPLETION.**

**Section II - To be completed by Employer and returned to Community Services.**

Hire Date: \_\_\_\_\_ Position: \_\_\_\_\_

**Please complete ONE of the following:**

1. Hourly	\$ _____	4. Weekly	\$ _____
2. Bi-Weekly	\$ _____	5. Monthly	\$ _____
3. Bi-Monthly	\$ _____	6. Annually	\$ _____

Average hours worked per week: \_\_\_\_\_ Weeks worked per year: \_\_\_\_\_

Vacation Pay (Y or N): \_\_\_\_\_ Number of days: \_\_\_\_\_

**ANTICIPATED additional ANNUAL INCOME from:**

1. Tips	\$ _____	3. Commissions	\$ _____
2. Bonuses	\$ _____	4. Overtime	\$ _____

Has employee been terminated? \_\_\_\_\_ If yes, is the individual eligible for unemployment benefits? \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Title:** \_\_\_\_\_

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**PHYSICIANS MEDICAL VERIFICATION**

Section I - To be completed by Applicant and returned to Community Services.

**PHYSICIAN'S NAME:** \_\_\_\_\_

**PHYSICIAN'S MAILING ADDRESS:** \_\_\_\_\_

**Applicant Name: (Print)** \_\_\_\_\_ **S.S. #:** \_\_\_\_\_

I hereby grant permission and authorize my physician to disclose full information as to my medical information to the Marion County CDBG Program where I have applied for assistance.

\_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Section II - To be completed by Physician and returned to Community Services.

**PHYSICIAN'S STATEMENT OF NEED**

This is to certify that \_\_\_\_\_ is a disabled person with a permanent disability that limits or impairs his/her ability to negotiate steps. The specific disability is checked below:

- Inability to walk without the use of or assistance from a brace, cane, crutch, prosthetic device, or other assistive device, or without assistance of another person and even with the assistive device, the person's ability to negotiate steps is severely limited.
- The need to permanently use a wheelchair.
- Severe limitation to a person's ability to walk due to an arthritic, neurological, or orthopedic condition.

\_\_\_\_\_

Print Name of Certifying Physician \_\_\_\_\_ Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Business Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_ LICENSED IN THE STATE OF: \_\_\_\_\_

Telephone Number \_\_\_\_\_

Certification or License No. (Required): \_\_\_\_\_ of Physician

WARNING: Any person who knowingly makes a false or misleading statement in an application or certification under section 320.0848, Florida Statutes, commits a misdemeanor of the first degree, punishable as provided in section 775.082 OR 775.083, F.S. The penalty is up to one year in jail or a fine of \$1,000 or both.