Central Florida Continuum of Care (FL507)

4065 L.B. Mcleod Road, Suite D, Orlando, FL 32811 ■ Phone: (407) 893-0133 ■ Fax: (407) 893-5299

APPLICATION FOR **INDIVIDUAL** AFFILIATE MEMBERSHIP

☐ Original

☐ Update

Name of Individual Applicant: _____

Applicant's primary agency/organizational affiliation *(if any)*: _____

Applicant's position/title with above agency/organization: _____

If the above agency/organization is an Organizational Member of the Central Florida Continuum of Care, are you currently designated as one of its Voting Members? *(max 5 per Organizational Member)*

☐ Yes ☐ No ☐ Not Sure

Please list all other agencies or organizations participating in the Central Florida Continuum of Care with which you are currently affiliated (as an employee, board member, volunteer, etc.) or with which you have been affiliated within the past twelve (12) months:

Name of Agency or Organization	When Did Affiliation End?	Type of Affiliation
	Month & Year: ____ / ____ ☐ N/A – Currently affiliated	☐ Staff ☐ Board ☐ Volunteer ☐ Other:_____
	Month & Year: ____ / ____ ☐ N/A – Currently affiliated	☐ Staff ☐ Board ☐ Volunteer ☐ Other:_____
	Month & Year: ____ / ____ ☐ N/A – Currently affiliated	☐ Staff ☐ Board ☐ Volunteer ☐ Other:_____
	Month & Year: ____ / ____ ☐ N/A – Currently affiliated	☐ Staff ☐ Board ☐ Volunteer ☐ Other:_____

_____*continue on back of sheet if needed*_____

Primary Email: _____

Primary Phone: _____

Address: _____

Street Address *City* *State* *ZIP Code*

Please check all sectors/constituencies/disciplines below that you currently represent or that are applicable to you:		**Please check all counties below in which you currently work or serve:**
☐ Local Government Staff/Official	☐ Affordable Housing Developer	☐ Orange
☐ State Government Staff/Official	☐ Public Housing Authority	
☐ CDBG/HOME/ESG Jurisdictional Admin	☐ School Admin/Homeless Liaison	
☐ Law Enforcement	☐ Funder	
☐ Jail	☐ Business	☐ Osceola
☐ EMT/Crisis Response Team	☐ Faith-Based Organization	
☐ Hospital	☐ University/College	
☐ Mental Health Services Agency	☐ Advocate – Youth	
☐ Substance Abuse Services Agency	☐ Advocate – Domestic Violence	☐ Seminole
☐ Nonprofit Homeless Assistance Provider	☐ Advocate – LGBTQ	
☐ Social Service Provider	☐ Advocate - Disability	
☐ Disability Services Provider	☐ Advocate – Other Hmls Population	
☐ LGBTQ Services Provider	☐ Shelter/Transitional Housing	☐ Other: _____
☐ Victim/Domestic Violence Provider	☐ Day Center/Day Program	
☐ Human Trafficking Provider	☐ Feeding Program/Soup Kitchen	
☐ Youth Homeless Agency	☐ I am Homeless/Formerly Homeless	
☐ Veteran Services	☐ Other: _____	
☐ Street Outreach		

I certify that the information provided above is current, accurate and complete to the best of my knowledge. I understand and agree that I am responsible for reporting any changes to the above information to membership@hsncfl.org. I further understand and agree that if I do not attend at least two (2) CoC FL-507 general or committee meetings during any 12-month period, I will be required to re-apply for membership.

Signature: _____ Date: _____

Applications may be submitted by email to membership@hsncfl.org; by U.S. mail to HSN, 4065-D L.B. McLeod Road, Orlando, FL 32811; or by hand to a CoC-designated representative at any CoC general or committee meeting. Any applicant who does not receive notification of application denial within 30 days of receipt by HSN may assume his or her membership application has been approved. Please note that the Applications for Organizational Affiliate Membership is a separate and distinct form.

Office Use Only: