



## Central Florida Commission on Homelessness (CoC FL-507)

142 E Jackson Street, Orlando, FL 32801 ■ Phone: (407) 893-0133 ■ Fax: (407) 893-5299

### APPLICATION FOR ORGANIZATIONAL MEMBERSHIP

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#### Instructions and Guidelines

**How to Submit an Application** Applications may be submitted by email to [membership@hcnfl.org](mailto:membership@hcnfl.org); by U.S. mail to HSN, 142 E Jackson Street, Orlando, FL 32801; 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 Application for Organizational Affiliate Membership is separate and distinct from Individual Affiliate Membership.

**Who are Designated Voting Members?** These are individuals authorized to make decisions on behalf of the organization. Typically, an organization will elect their CEO/Executive Director, members of their leadership, and management teams. Each organization must elect voting members and may select up to five (5) persons. Voting members are considered members of the CFCH per their active membership with the listed organization. If the individual departs from the member organization, they should complete the Individual Affiliate Membership Application to maintain their membership with the CFCH.

**How do we contact you?** General contact information for your organization as well as contact information for all Designated Voting Members is required for general correspondence as well as for providing information on items that mandate a decision by designated voting members.

**What best describes your organization?** In this section, we ask you to indicate all the sectors/constituencies/disciplines that are applicable to the applicant organization by checking the boxes. Check all that apply. If there is an area, activity, or sector not included in the list, please note it under "Other".

**Where does the applicant organization serve?** This question aims at identifying the service area for the organization. Please check all the counties in which the organization operates or serves. If a county is not listed, you may include it under "Other".

**Certification Section** This section ensures we know who is submitting the application. It also ensures that your organization understands the basic requirement for maintaining membership with CFCH/CoC FL-507. To maintain active membership, your organization must have representatives in at least two (2) CoC FL-507 general or committee meetings during any 12-month period. If this does not occur, you will be required to re-apply for membership.

**Questions or Concerns** If you have any questions or concerns in relation to your membership with CoC FL-507, you may send an email to [membership@hcnfl.org](mailto:membership@hcnfl.org).

To stay informed about CFCH updates and notifications, please visit [www.cfch.org](http://www.cfch.org) and sign up for email updates.

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### Application Questions

Name of Organization: \_\_\_\_\_

Is this a new application or updated application?    New       Updated

Organization Email: \_\_\_\_\_

Organization Phone: \_\_\_\_\_

Address: \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP Code*

Name of Individual Submitting the Application: \_\_\_\_\_

Title/Position in Organization: \_\_\_\_\_

Email: \_\_\_\_\_

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

*If the person listed above is not the head of the organization (e.g., Executive Director, CEO, President), please provide the head's contact details below and have them sign.*

Name: \_\_\_\_\_

Title/Position in Organization: \_\_\_\_\_

Email: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Which best describe this organization: <i>(Check all that apply)</i>	Where does this organization serve:
<input type="checkbox"/> Local Government Staff/Official <input type="checkbox"/> State Government Staff/Official <input type="checkbox"/> CDBG/HOME/ESG Jurisdictional Admin <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Jail <input type="checkbox"/> EMT/Crisis Response Team <input type="checkbox"/> Hospital <input type="checkbox"/> Mental Health Services Agency <input type="checkbox"/> Substance Abuse Services Agency <input type="checkbox"/> Nonprofit Homeless Assistance Provider <input type="checkbox"/> Social Service Provider <input type="checkbox"/> Disability Services Provider <input type="checkbox"/> LGBTQ Services Provider <input type="checkbox"/> Victim/Domestic Violence Provider <input type="checkbox"/> Human Trafficking Provider <input type="checkbox"/> Youth Homeless Agency <input type="checkbox"/> Veteran Services Provider <input type="checkbox"/> Street Outreach	<input type="checkbox"/> Affordable Housing Developer <input type="checkbox"/> Public Housing Authority <input type="checkbox"/> School Admin/Homeless Liaison <input type="checkbox"/> Funder <input type="checkbox"/> Faith-Based Organization <input type="checkbox"/> University/College <input type="checkbox"/> Advocate – Youth <input type="checkbox"/> Advocate – Domestic Violence <input type="checkbox"/> Advocate – LGBTQ <input type="checkbox"/> Advocate – Disability <input type="checkbox"/> Advocate – Other Hmls Population <input type="checkbox"/> Shelter/Transitional Housing Provider <input type="checkbox"/> Day Center/Day Program <input type="checkbox"/> Feeding Program/Soup Kitchen <input type="checkbox"/> I am Homeless/Formerly Homeless <input type="checkbox"/> Other <i>(please specify)</i> :
	<input type="checkbox"/> Orange  <input type="checkbox"/> Osceola  <input type="checkbox"/> Seminole  <input type="checkbox"/> Other: <i>(please specify)</i>

### Appointment of Voting Members

List up to 5 designated voting members. *Please include the individual submitting the application and the head of the organization if they will vote.*

Name	Email	Position/Title	Phone

### Points of Contact for CoC Initiatives

Please provide a Point of Contact for PIT Count coordination.

Name	Email	Position/Title	Phone

Please provide a Point of Contact to serve as your organization's HMIS liaison.

Name	Email	Position/Title	Phone

Please provide a Point of Contact for extreme weather and disaster preparedness coordination.

Name	Email	Position/Title	Phone

Please provide a Point of Contact for lived experience initiatives.

Name	Email	Position/Title	Phone

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](mailto:membership@hsncfl.org). I further understand and agree that if, \_\_\_\_\_, does not have representatives in 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: \_\_\_\_\_