



ORANGE COUNTY PUBLIC BURIAL & CREMATION PROGRAM

FACSIMILE TRANSMITTAL SHEET

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|-----------------------------|--|
| TO: | FROM: Delisa Craig MSW |
| COMPANY: | DATE: |
| PHONE NUMBER: | TOTAL NO. OF PAGES INCLUDING COVER: 4 |
| FAX NUMBER: | SENDER'S FAX NUMBER: 407.836.1973 |
| RE: Forms To Claim Ashes | YOUR REFERENCE NUMBER: |

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

NOTES/COMMENTS:

Please complete the attached forms and return with the documents listed below:

- Copy of your photo ID
- Current bank statement(s)
- Proof of household income for the last 4 weeks
- Proof of Kinship

Please return documents via:

Mail: Orange County Medical Clinic ATTN: Delisa Craig **Fax:** 407.836.1973
101 S. Westmoreland Drive
Orlando, FL 32805

Our Contracted Provider:

Waldon Funeral Home: 321.363.1592, 710 Lexington Green Lane Sanford, FL 32771

To Obtain a Death Certificate:

Vital Statistics: 407.858.1460, 807 W. Church St. Orlando, FL 32805

For questions, please call Delisa Craig MSW, Sr. Community Services Worker at: 407-836-2642

Orange County Public Burial and Cremation Program Application

DECEDENT INFORMATION

| | | |
|---------------------|----------------|---|
| Name of deceased: | | |
| Date of birth: | Date of death: | SSN: |
| Last known address: | | |
| City: | State: | ZIP Code: |
| Marital status: | Income: | Assets (including life insurance policy): |

APPLICANT INFORMATION

| | | |
|-------------------------------------|--------|-----------|
| Name of person requesting services: | | |
| Address: | | |
| City: | State: | ZIP Code: |
| Telephone number: | | |
| Relationship to decedent: | | |

APPLICANT'S HOUSEHOLD MONTHLY INCOME INFORMATION

| | | |
|---|------------------------------|-------------------------|
| Number in household: | Adults: | Children: |
| List ALL adults, sources of income, and amount of income: | ALL income MUST be reported: | Total household income: |
| Name: | Income: | Source of income: |
| Name: | Income: | Source of income: |
| Name: | Income: | Source of income: |
| Name: | Income: | Source of income: |

APPLICANT'S HOUSEHOLD EXPENSES INFORMATION

| | | |
|---------------------------------------|------------------|-----------------|
| Paid to: | Amount paid: | How often paid: |
| Paid to: | Amount paid: | How often paid: |
| Paid to: | Amount paid: | How often paid: |
| Paid to: | Amount paid: | How often paid: |
| Do you rent / own? | Monthly payment: | |
| Total amount of ALL monthly expenses: | | |

APPLICANT'S ASSET INFORMATION

| | |
|-------------------------|----------|
| Checking account (Y/N): | Balance: |
| Savings account (Y/N): | Balance: |

INCOMPLETE APPLICATIONS MAY RESULT IN DELAY OR IMMEDIATE DENIAL OF SERVICES

All programs are open to all without regard to race, color, national origin, sex, handicap, familial status, or religion. Assistance is provided according to the availability of funding; some restrictions apply. I certify that all information I have provided above is true and correct. I/we understand that 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. I/we further understand that any willful misstatement of information will be grounds for disqualification. I/we certify that the application information provided is true and complete to the best of my/our knowledge. I/we consent to the disclosure of information for the purpose of income verification related to making a determination of my/our eligibility for program assistance. I/we agree to provide any documentation needed to assist in determining eligibility and are aware that all information and documents provided are a matter of public record. I/we further understand that if any misrepresentation or fraudulent statement is discovered after assistance has been provided the County will demand and pursue through all legal remedies available, repayment of the funds provided for the assistance that was provided.

Applicant Signature _____ Date _____

OFFICE USE ONLY: I certify that, to the best of my knowledge, the applicant does not have sufficient resources to pay for burial or cremation. **Income below current federal poverty level: Y/N**

Senior Community Services Worker/ Date

Orange County
Health Services Department

Legally Responsible Party

X DECEDENT: _____

X DOB: _____

CASE #: _____

Under Florida Law, Orange County is the legally responsible party for the disposition of the body of the above referenced decedent.

I am aware that Orange County intends to follow its standard policy of cremation and will be cremating the decedent.

If I desire a burial instead of a cremation, I may request information from the Orange County Health Services Program Caseworker.

X Family Signature: _____ X Date: _____

X Relationship to Decedent: _____

Orange County Program Staff Signature: _____

Title: _____ Date: _____

Orange County Public Burial and Cremation Service Program

Closest Relative

CASE/CRNA #: _____

X Decedent: _____ X Race: _____ X Sex: _____

X DOB: _____ X SS: _____

X DOD: _____ Time of Death: _____

→
Initial
Here

I am the closest relative/legally responsible party of the decedent and **confirm that I am NOT claiming the body**. I understand that Orange County is the legally responsible party for unclaimed bodies and will provide cremation services according to the existing Orange County regulations, guidelines and procedures for the disposition of unclaimed bodies.

I understand that Orange County may file a claim against the estate of the deceased person, if any exists, to recover the cost of services provided by this program, including probate court costs, if allowed by law.

Although I am not claiming the body, I understand that I may pay Orange County the additional cost of \$ _____ as reasonable accommodation of my request for burial.

→
Initial
Here

- I hereby waive the option to pay the above stated sum and agree to cremation.
- I will pay Orange County the indicated sum to provide the burial of the deceased.
- In the event of cremation, I would like to receive the cremated remains. Cremains must be picked up or shipped within 30 days. The responsible party bears shipping costs.

→
Initial
Here

I am the closest relative/legally responsible party of the decedent and **confirm that I AM claiming the body**. Orange County shall no longer be responsible for the body/remains of the decedent. The claiming party has accepted financial responsibility and agrees to pay the charges that are associated with any services rendered by authorization of Orange County.

_____, (contract service provider) is hereby authorized and directed by Orange County to release the body/remains of the decedent to:

Funeral Home/Burial Service: _____

I agree to indemnify, release and hold Orange County, its agents and employees harmless from any and all loss, printed errors, damages, liability or causes of action (including attorney's fees and expenses of litigation) in connection with the burial/cremation and disposition of the cremated remains of the deceased. **Orange County's responsibility ends immediately upon this notice** and will not be responsible for the claiming party's failure to make payment.

X Signature: _____

X Print Name: _____ X Telephone: _____

X Address: _____ X State/Zip: _____

X Relationship to deceased: _____

Orange County Health Services
Public Burial & Cremation Program
101 S. Westmoreland Drive Orlando, FL 32805
Phone: (407) 836-2642 Fax (407) 836-7165