MARTIN COUNTY HUMAN SERVICES
435 SE FLAGLER AVE., STUART, FL 34994
Phone: (772) 288-5785 Fax: (772) 223-4829

CREMATION ASSISTANCE APPLICATION

DECEDENT INFORMATION

NAME:_____

SOCIAL SECURITY NO:_____ MARITAL STATUS:_____

D.O.B.:_____ D.O.D.:_____

ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____

PASSED AWAY IN MARTIN COUNTY: YES☐ NO☐ VETERAN: YES☐ NO☐

PLEASE LIST DECEDENT'S ASSETS:_____
(Please include home(s), insurance policies, cars, etc.)

APPLICANT INFORMATION

NAME:_____

PHONE:_____ RELATION TO DECEDENT:_____

ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____

TOTAL GROSS MONTHLY INCOME:_____
(Please include all wages, unemployment, child support, SSI, TANF, etc. for applicant's entire household; If next of kin, income documentation must be provided.)

_____ _____
Signature of Authorized Representative Date

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CLIENT CONSENT FOR DATA COLLECTION AND RELEASE OF INFORMATION

This client notice and consent describes how information about you may be used and collected for the purpose of providing the service you have applied for and how you can have access to this information. In order for a service to be provided, this form **MUST** be signed.

I, _____, understand and acknowledge that Martin County Human Services uses a digital client tracking system and I consent to and authorize the collection and retention of my information for the purpose of the service(s) I am applying for. I understand that such information may include, but is not limited to the following:

- Identifying information (name, birth date, gender, race, social security number, residential information, phone number, family information, etc.)
- Financial information (income verification, public assistance payments and allowances, food stamp allotments, etc.)
- Medical records (HIV/AIDS diagnosis, psychological records and evaluations, vocational assessments, care coordinators recommendations/direct observation, employment status, etc.)
- Substance abuse diagnosis, treatment plans, progress in treatment, and discharge information
- Other (As specified in the space provided) _____

  _____

Additionally, please review the following bullet points:

- I understand that Martin County Human Services may contact my employer, bank, family/friends, or any other institution(s) or person(s) to verify information and confirm my eligibility for the program(s) I am applying for.
- I understand that I have the right to inspect, copy, and request all records maintained by the Agency relating to the provision of services to me and to receive a paper copy of this form.
- I understand that this release can be revoked by me at any time and that the revocation must be signed and dated by me. If not previously revoked, this consent terminates automatically **ONE YEAR** after this form has been signed.
- I understand that my records are protected by Federal, State, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent, unless otherwise provided for in regulations.

_____ _____

Client Signature Date

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MARTIN COUNTY CREMATION AUTHORIZATION FORM

DECEDENT INFORMATION

NAME:_____

ADDRESS:_____

SOCIAL SECURITY #:_____ – _____ – _____ ☐ ADULT ☐ CHILD ☐ INFANT

DATE OF BIRTH:_____ DATE OF DEATH:_____

LEGALLY AUTHORIZED PERSON INFORMATION

I DO HEREBY AUTHORIZE MARTIN COUNTY TO PROVIDE FOR FINAL DISPOSITION

OF _____ BY CREMATION.†
Decedent's Full Name

PRINTED FULL NAME:_____

ADDRESS:_____

PHONE:_____ RELATION TO DECEDENT:_____

SIGNATURE:_____ DATE:_____

BELOW TO BE COMPLETED BY NOTARY PUBLIC

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____,

by _____.

_____
Signature - Notary Public, State of Florida

_____
Typed, Printed, or Stamped - Notary Public, State of Florida

Personally Known:_____ OR Produced Identification:_____ Type of Identification:_____

†The completion of this form does not guarantee that Martin County will be responsible for final disposition services. Final approval shall be determined by staff of the Martin County Community Services Program in accordance with Florida Statute 497.005 (39), and with program guidelines.

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AUTHORIZATION TO RELEASE

DECEDENT INFORMATION

NAME:_____ D.O.B.:_____ D.O.D.:_____

AGE:_____ SEX:_____ RACE/ETHNICITY:_____ ME CASE #:_____

LEGALLY AUTHORIZED PERSON INFORMATION

I, _____, certify that I am the "legally authorized person"*
Legally Authorized Person's Full Name

and do hereby authorize_____ to release
Name of Organization in Possession of Remains

the remains of the above decedent to All County Funeral Home & Crematory.

SIGNATURE:_____ DATE:_____ TIME:_____

RELATION TO DECEDENT:_____ PHONE:_____

ADDRESS:_____

WITNESS:_____ DATE:_____ TIME:_____

FUNERAL HOME
REPRESENTATIVE:_____ DATE:_____ TIME:_____

***"Legally Authorized Person"** means, in the priority listed below, per Florida Statute 497.005 (43):

I. **Next of kin**:
1. Spouse
2. Adult Child (if no spouse)
3. Parent (if no spouse or children)
4. Adult Brother/Sister (if no 1,2,3)
5. Adult Grandchild or Grandparent (if no 1,2,3,4)
6. Next Degree of Kinship:_____

II. **Person at time of death when there is no family:**
1. Guardian
2. Personal Representative
3. Attorney in Fact
4. Health Surrogate
5. Public Health Officer
6. County Commission
7. Other:_____

RELEASE INFORMATION

REMOVAL DATE:_____ TIME:_____ VALUABLES RECEIVED: YES___ NO___

FUNERAL HOME: _____ REPRESENTATIVE:_____