


Orange County Public Burial and Cremation Service Program


Closest Relative


Decedent: _____ CASE/CRNA #: _____

DOB: _____ Race: _____ Sex: _____


DOD: _____ SS: _____

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

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. **INITIAL:** _____ 

I hereby declare that I do not know of any person in the next degree of kinship to have any objections to in my decision to utilize this program in my effort to either casket bury, claim the cremated remains or not claim the cremated remains. **INITIAL:** _____ 

I agree to cremation. **INITIAL:** _____ 

In the event of cremation, I would like to receive the cremated remains. Cremains must be picked up or shipped within 30 days. The Orange County Public Burial & Cremation Program does not cover the cost of shipping the cremains. The applicant bears shipping costs. **INITIAL:** _____ 

Although I am not claiming the body, I understand that I may request for Orange County to complete a Veteran casket burial based off of the Decedent's eligibility per the Veteran's Administration. **INITIAL:** N/A

I am requesting a direct Veteran casket burial for the Decedent. **INITIAL:** N/A

I understand that interment is based off of eligibility to be determined by the Veteran's Administration. **INITIAL:** N/A

I will provide any documentation I have to support the above named Decedent is a Veteran. **INITIAL:** N/A

Signature: _____

Print Name: _____ Telephone: _____

Address: _____ State/Zip: _____

Relationship to deceased: _____

Orange County Health Services
Public Burial & Cremation Program
101 S. Westmoreland Drive Orlando, FL 32805
Phone: (407) 836-2642 Fax (321) 321-8216

PBCP Form 4

Orange County Public Burial and Cremation Program

Legally Responsible Party

1. Decedent name
First Name *Middle Name* *Last Name*

2. Decedent date of birth
MM *DD* *YY*

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 Program Office Staff.

Your printed name
First Name *Middle Name* *Last Name*

Your signature

Signature date
MM *DD* *YY*

Office use only:

Case number

Program Office Staff Signature: _____

Date: ____ / ____ / ____

Orange County Health Services Department
Public Burial and Cremation Program
101 S. Westmoreland Drive, Orlando, FL 32805
Program office: 407-836-2642 Fax: 321-321-8216

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**

Program Office Staff/ Date

Orange County Health Services
Public Burial & Cremation Program
101 S. Westmoreland Drive Orlando, FL 32805
Phone: (407) 836-2642 Fax (321) 321-8216



Declaration to Claim Decedent's Cremains

Name: _____

Address: _____

Phone number: _____

Legal relationship to the decedent: _____

I hereby declare that I do not know of any person in the next degree of kinship to have any objections in my claiming the cremains for Decedent name: _____

Claimant signature and signature date:

_____ / ____ / ____

The undersigned further understands that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of the processing of this application.

To be considered for services from Orange County Public Burial and Cremation Program, this form must be notarized.

Notary Certification:
STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____ by _____, who is personally known to me or who has produced _____ as identification.

(Name of Notary)

(Notary Signature)



**HEALTH SERVICES DIVISION
MEDICAL CLINIC**

101 South Westmoreland Drive • Orlando, Florida 32805-2258
407-836-2642 • Fax 321-321-8216

Please complete this entire form if you are only authorizing someone other than yourself to pick up the ashes

Authorization to Release Ashes

To Whom It May Concern:

I, _____ (Name and Relationship to Decedent)

give my authorization to _____(Name) to pick up the

ashes of _____(Decedent's Name) on my behalf.

Signature: _____

Date: _____

Witness: _____

Date: _____

Please include the contact information of the person claiming the cremated remains

below:

Address: _____

City/State: _____

Phone Number: _____

E-Mail Address: _____

*****Person picking up ashes must present their photo identification at time of pick up**.***

