Maine Department of Health and Human Services
Office of Behavioral Health
BRIDGING RENTAL ASSISTANCE PROGRAM (BRAP)
APPLICATION

First Name: _____ **Last Name:** _____

Gender: ☐ Male ☐ Female ☐ Transgender Other

Social Security Number: _____ **DOB**:_____

Veteran: YES ☐ **NO** ☐ **Are you Hispanic or Latino?** ☐ Yes ☐ No

Race (check all that apply):

☐ American Indian or Alaskan Native
☐ Black or African-American
☐ White or Caucasian
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Other: _____

Mailing Address: _____

Telephone Number: _____ **Email:** _____

Preferred Counties (1st & 2nd choice): _____

***Completed application should be sent to agency that serves your first choice county-**see Appendix D

1. Are you an AMHI Consent Decree Class Member? **YES** ☐ **NO** ☐

*(A Consent Decree Class Member is someone who was hospitalized at AMHI/Riverview Psychiatric Center on, or after January 1, 1988.)

2. Do you meet Eligibility for MaineCare Community Support Services? **YES** ☐ **NO** ☐

*(As defined in Section 17 of the MaineCare Benefits Manual)

If yes, complete Appendix A-*Eligibility Verification*; If no, Complete Appendix B-*BRAP Enrollment Form*

3. Are you currently receiving SSI or SSDI, or have you applied, or are you actively appealing a denial? (Please attach documentation) **YES** ☐ **NO** ☐

4. Are you currently, or will you be on a waitlist for federally subsidized housing, such as Section 8 or HCV? (Please attached documentation) **YES** ☐ **NO** ☐
If 'No' why? _____.

5. What is the best way to get in contact with you? (please check all that apply).

Phone: ☐ _____

Email: ☐ _____

Mail: ☐ _____

Other ☐ _____

6. Do you have a preferred language, other than English? (Specify):_____

An interpreter service is available upon request. Please notify the program if alternative methods are needed.

7. Correspondence: Do you want us to copy all correspondence to your referral source or other service provider? If yes, please provide name, address, and phone number for all that apply.

Payee:_____

Case Manager: _____

Guardian: _____

Service Provider: _____

8. Household Composition: Please list everyone who will be residing in the household.

Name:	Relationship to Applicant:	Pregnant?
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No

9. Applicant Income & Other Assistance Sources: (*Please attach current verification of income.)*

Income Sources		**Other Assistance Sources**
No financial resources ☐		☐ None
Supplemental Security Income (SSI)	$_____	☐ SNAP / Food Stamps
Social Security Disability Income (SSDI)	$_____	☐ Medicare
Social Security	$_____	☐ Medicaid (MaineCare)
Employment income	$_____	☐ SCHIP
General Public Assistance (GA)	$_____	☐ VA Medical Services
Unemployment benefits	$_____	☐ WIC
Temporary Aid Needy Families (TANF)	$_____	☐ TANF (Child Care / Transp.)
State SSI Supplement	$_____	☐ Indian Health Services
Other (Source): _____	$_____	☐ Employer Provided Insurance
TOTAL Monthly INCOME:	$_____	☐ Other: _____

10. <u>Please Select Priority</u> under which the applicant is applying. ***<u>All applicants MUST include verification of priority</u>***

Documenting Priority: Verification should include the start/end dates of qualifying situation(s), including dates, length of stay, and location/facility as applicable to each priority. Verification letters should be on an agency letterhead and signed by provider providing verification.

☐ **<u>Priority 1: Psychiatric Discharge after seventy-two (72) hour or greater psychiatric inpatient hospital admission</u>**

a. Individuals who are being discharged, or were discharged within the past thirty (30) days from:
   - Riverview Psychiatric Center or Dorothea Dix Psychiatric Center, or;
   - A private psychiatric hospital or facility, or;

b. Individuals who are moving from a Community Residential Treatment Program (Mental Health PNMI) to less restrictive accommodations to allow for appropriate discharges, as determined by the clinical team from the institutions mentioned above.

Examples include, but are not limited to: KEPRO Authorization, Hospital Discharge Paperwork, Letter from provider, etc

☐ **<u>Priority 2: Release from a Correctional Facility</u>**

a. Applicants who have been released within the last thirty (30) days or will be released within the next thirty (30) days, from a Correctional Facility and have no subsequent residences identified, or have been adjudicated through a Mental Health treatment court.

Examples include, but are not limited to: Letter from ICM/Dept of Corrections, Release paperwork, etc

☐ **<u>Priority 3 Literal Homelessness, as defined by HUD</u>**

An individual or family who:

- Lacks a fixed, regular, and adequate nighttime residence, meaning: Has a primary nighttime residence that is a public or private place not meant for human habitation; **or**
- Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); **or**
- Is exiting an institution (i.e., incarceration, hospitalization) where they have resided for 90 days or less and who were homeless before entering that institution.

Applications received under Priority 3 are ranked according to length of homelessness, with those being homeless the longest as the top priority.

For Priority 3, if the provider has witnessed homelessness, please include all known dates/locations, with the most recent being within 14 days of application submission.

Examples of Priority verifications include, but are not limited to: Hospital discharge paperwork; Letter from Homeless provider, Letter from agency providing emergency assistance, Letter from Outreach Worker witnessing situation, etc

Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station – 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), 1-800-606-0215 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.

Applicants are encouraged but not required to engage in services as a condition of acceptance into the Bridging Rental Assistance Program.

APPLICANT:

Tenant's Certification: I/We certify that the information contained in this application is true and complete to the best of my/our knowledge and belief.

Print Applicant Name	Applicant Signature	Date
Print Name–Other Adult Member	Other Adult Member Signature	Date

APPENDIX A

ELIGIBILITY VERIFICATION

I hereby affirm the above-enclosed information concerning current housing situation, current address, and eligibility criteria are true and accurate for this client as indicated above; and

1. I verify the Applicant meets the Eligibility For Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual or is already enrolled in PNMI services:

CHECK APPROPRIATE BOX and ATTACH VERIFICATION:

i. ☐ Applicant is already enrolled in Adult Mental Health Services funded Community Support (Section 17) and/or PNMI services (Section 97)—verification of enrollment with KEPRO HealthCare or DHHS attached; **OR**

ii. ☐ No KEPRO HealthCare or DHHS Adult Mental Health Enrollment form is currently on file. I have attached a completed BRAP Enrollment Form to provide a mental health diagnosis or have attached such a signed qualifying diagnosis my agency deems appropriate to document eligibility for services under Section 17 as may be approved by KEPRO HealthCare and/or DHHS to the BRAP Enrollment Form.

Referring Agency: _____

_____	_____	_____
Printed Name	Signature	Date

APPENDIX B

Office of Adult Mental Health Services
BRAP ENROLLMENT FORM

To be completed ONLY for persons not already Enrolled in Section 17 Services AFTER April 7, 2016

Client Information:

Name: _____

Date of Birth: _____

Social Security Number: _____

Diagnosis and LOCUS Information:

Primary Diagnosis : _____

Date Given: (within 12 months):_____

LOCUS Score:_____Rater ID:_____

Date Given (within 12 months):__ _____

Requirements for Eligibility. A person is eligible to receive covered services if he or she meets both general MaineCare eligibility requirements and specific eligibility requirements for Community Support Services under Section 17 of the MaineCare Benefits Manual.

General Requirements. Individuals must meet the eligibility criteria as set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

Risk Factors: Documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis.

Specific Requirements. A member meets the specific eligibility requirements for covered services under this section if:

A. The person is age eighteen (18) or older or is an emancipated minor with:

1. A primary diagnosis of Schizophrenia or Schizoaffective disorder in accordance with the DSM 5 criteria; or
2. Another primary DSM 5 diagnosis or DSM 4 equivalent diagnosis with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders who:
   a) has a written opinion from a clinician, based on documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homelessness, criminal justice involvement or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided; based on documented or reported history; for the purposes of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver; or
   b) has received treatment in a state psychiatric hospital, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
   c) has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
   d) has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
   e) has been committed by a civil court for psychiatric treatment as an adult; or
   f) until the age of 21, the recipient was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a clinician, in the last 12 months, stating that the recipient had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

AND

B. Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the LOCUS or other acceptable standardized assessment tools approved by the Department. If using the LOCUS, the member must have a LOCUS score, as determined by a LOCUS Certified Assessor, of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services (17.04-2) and ACT (17.04-3), the member must have a LOCUS score of twenty (20) (Level IV) or greater.

C. Eligible members who are eighteen (18) to twenty-one (21) years of age shall elect to receive services as an adult or as a child. Those members electing services as an adult are eligible for services under this Section. Those electing services as a child may be eligible for services under Chapter II, Section 65, Behavioral Health Services or Section 13 or both.

D. The LOCUS or other approved tools must be administered, at least annually, or more frequently, if DHHS or an Authorized Entity requires it.

History Of (check all which apply):

- ☐ Has received treatment in a state psychiatric hospital, within the past 24 months;
- ☐ Has been discharged from a mental health residential facility, within the past 24 months;
- ☐ Has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months;
- ☐ Has been committed by a civil court for psychiatric treatment as an adult;
- ☐ Until the age 21, the recipient was eligible as a child with severe emotional disturbance.*

  * If selecting this qualifier, please indicate a written opinion stating that the recipient, in the last 12 months, had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

Based on documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of (check all which apply):**

- ☐ Homelessness;
- ☐ MH Residential treatment;
- ☐ MH inpatient greater than 72 hours;
- ☐ Criminal Justice involvement.

** Reported history may include oral or written history from the client, a provider, or a caregiver

Signatures and Certifications:

I, _____, certify and attest that the diagnostic
Clinician Signature
information listed on the previous page (6) are in accordance with the Specific Requirements section of this form (Part A, paragraph 2, sub-paragraph a) and is true and complete to the best of my knowledge and belief.

_____

Print Name and Credentials ***(must be MD, LCSW, LCPC, PhD, APRN, NPC, PA or DO)***

Date:_____

APPENDIX C

Before submitting your application, double check to be sure you have the following documents included:

_____**SSI/SSDI confirmation (**Copy of award letter **OR** documentation of appeal request)

_____**Federally subsidized housing waitlist confirmation** (Documentation of application for waitlist **OR** Explanation of denial)

_____**Other income verification** (if applicable)

_____**Verification of priority** (see verification of priority section for examples)

_____**Eligibility verification** (Signed Eligibility Verification with documentation of Kepro enrollment **OR** Signed BRAP Enrollment Form)

_____**Applicant Signature** (page 5)

Appendix D

SUBMITTING YOUR COMPLETED APPLICATION

For more information or to submit a completed application, please contact one of the following agencies depending on County preference.

ANDROSCOGGIN, FRANKLIN, AND OXFORD COUNTIES

Common Ties

P.O. Box 1319

Lewiston, ME 04243

Tel. 207-795-6710 Fax: 207-795-6714 (Attn: Housing Subsidies) Email: info@commonties.org

YORK, CUMBERLAND, KNOX, LINCOLN, SAGADAHOC, AND WALDO COUNTIES

Shalom House, Inc.

106 Gilman Street

Portland, ME 04102

Tel. 207-874-1080 Fax: 207-874-1077 (Attn: BRAP) Email: brapapplications@shalomhouseinc.org

AROOSTOOK, HANCOCK, PENOBSCOT, PISCATAQUIS, AND WASHINGTON COUNTIES

Community Health & Counseling Services

P.O. Box 425

Bangor, ME 04402-0425

(42 Cedar Street, Bangor, ME 04401)

Tel. 207-947-0366 Fax: 207-945-4465 (Attn: Rental Services) Email: rentalservices@chcs-me-org

KENNEBEC AND SOMERSET COUNTIES

Kennebec Behavioral Health

67 Eustis Parkway

Waterville, ME 04901

Tel. 207-873-2136 Fax: 207-660-4532 (Attn: Rental Services) Email: rentalservices@kbhmaine.org