Crisis Housing Assistance Program Application

For Persons with a Serious Mental Illness

Funded through the Minnesota Department of Human Services (DHS), Adult Behavioral Health Division

Administered by The Arc Minnesota

The Crisis Housing Assistance Fund is a flexible pool of money to provide short-term housing assistance for persons with a serious mental illness whose income is being used to pay for an inpatient, residential treatment, or partial hospitalization program of 90 days or less.

The State of Minnesota identifies a serious mental illness diagnosis as one "that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation

The goal of this program is to help individuals remain in their home while seeking treatment for up to 90 days in a licensed facility. The grant can **only** be used for current rent, utilities, garbage, water/sewer, and phone (up to $70 per month).

Individual MUST be seeking treatment in one of the following manners:
In-Patient or Residential Mental Health Care
In-Patient or Residential Substance Use Disorder Care (must provide documentation of Severe Mental Illness)
Partial Hospitalization

Out-Patient Treatment of any kind does not meet eligibility guidelines.

The following must be included with your application:

- Proof of income (copy of participants bank account information and the screenshot of direct deposit from employment, unemployment, SSI payment, SSDI payment, etc) with identifying information.
- A budget detailing expenses and who to pay must be included when submitting an application.
- Signed Release of Information
- Signed Verification form of Serious Mental Illness if seeking treatment through a Substance Use Disorder Center

Funding Details:

Funds can only be used to pay for eligible housing and utility costs accrued while in treatment.

Funds will not be paid directly to the applicant. All payments will be made directly to the landlord, utility service or phone company. You will need to provide information as to whom to pay, address and include account numbers for services.

Funds **only** cover the retention of the applicants current housing and cannot be used for damage deposit or down payment.

Once a completed application is received, you will be contacted.

Payment will be made within 3-7 business days once eligibility is verified and all documents are submitted.

Please email or fax your completed application and documentation to: wendygerlach@arcminnesota.org or fax to 952-522-3604

For more information or assistance, please contact:
Wendy Gerlach
952-915-3698
wendygerlach@arcminnesota.org

Crisis Housing Assistance Program Application

For Persons with a Serious Mental Illness

Funded through the Minnesota Department of Human Services (DHS), Adult Behavioral Health Division

APPLICANT INFORMATION:

Applicant Full Name:_____

Date of Birth_____ SS#_____

Gender:_____ Race/Ethnicity:_____

Street Address:_____

_____

City_____State:_____

Zip:_____County:_____

Phone:_____

Email address:_____

Monthly household income: $_____ Please submit documentation

Source of Income:_____

Household size: _____Number of adults:_____ Number of dependents:_____

Have you previously received funds through the Crisis Housing Assistance Program? Yes ◯ No ◯

Income Limits to apply (household size) Gross Income

1 Person $58,250 2 Person $66,550 3 Person $74,900 4 Person $83,200 5 Person $89.850 6 Person $96,500,7 Person $103,150 8 Person $109,800

Requested Financial Assistance:

Utility Type	**Amount**	**Check payable to: must include account number—list on separate sheet of paper if necessary**
Rent or Mortgage (circle one) ◯ ◯	$	
Electricity:	$	
Heating:	$	
Garbage:	$	
Water/Sewer:	$	
Phone (Max $70 month)	$	
Other (list):		
MONTHLY TOTAL:		
# OF MONTHS (MAX 3):		
TOTAL REQUEST:		

Crisis Housing Assistance Program Application (Page 2)

For Persons with a serious Mental Illness

Funded through the Minnesota Department of Human Services (DHS), Adult Behavioral Health Division

Administered by The Arc Minnesota

- **Covers** housing related expenses a client is paying, but cannot now pay because their income is being used for treatment OR due to the loss of income while in treatment.
- **Covers** rent, mortgage, utilities (heating fuel, electricity, water, sewer, garbage disposal, and phone).
- **Funds** only cover the retention of the client's current housing and cannot be used for damage deposit or downpayment.
- **Cannot** be used for crisis beds, adult foster care, residents in assisted living, nursing homes, group homes, or board and lodge.
- **Cannot** be used to pay past due bills that occur outside the treatment period.

Treatment Center Information -Must be a licensed In-Patient or Residential Mental Health Care Facility, licensed In-Patient or licensed Residential Substance Use Disorder Care (with Severe Mental Health Illness Documentation), or Partial Hospitalization

Name of Treatment Center:_____

Contact Name at Treatment Center:_____

Phone number:_____

Email:_____

Street Address:_____

City:_____ State:_____ Zip: _____

Dates of Treatment: _____/_____/_____ through _____/_____/_____

Verification of in-patient/residential psychiatric or chemical dependency treatment services during the period listed above.

Agency Referring Applicant (if any): _____

Agency Type (Agency Name, Social Worker, Case Manager, and any disability service provider):

_____

Agency Contact Information

First Name:_____ Last Name:_____

Phone Number:_____ email address:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Applicant Signature will confirm all details in application are true and approval of consent of release of information

Signature of Applicant:_____

Print Name:_____

Date:_____

The Arc
Minnesota

Consent for Release of Information
Crisis Housing Assistance Program

I/we _____,
do hereby authorize the exchange of information described below. I have been informed of the intended purpose and the use of this exchange, and that this information will not be further released without my written consent.

I understand that The Arc Minnesota Crisis Housing Assistance Program Staff are required, by law, to report any suspected abuse that I share with them. I understand that I can also request other resources to support me.

The following parties:

Name	Individual/Crisis Housing Assistance Program
Agency	The Arc Minnesota
Phone	952-915-3698
Fax **email**	952-522-3604 wendygerlach@arcminnesota.org

Have my express permission to exchange the following information

☐ Verification of serious mental health illness

☐ Verification that I am seeking treatment at an inpatient mental health facility

☐ Verification that I am seeking treatment at an eligible Substance Use Disorder treatment center that can verify serious mental health illness

☐ Verification of Gross Household Income

☐ Other, please specify _____.

I believe this exchange of information to be in my best interests. I understand that I may cancel this consent, not retroactive, upon written notice. I understand this consent will automatically expire one year after the date of my signature.

_____
Individual Date

_____
Guardian Date