Department of Mental Health & Addiction Services
Emergency Housing Assistance Fund (HAF)
Client Application

The Department of Mental Health and Addiction Services (DMHAS) developed the Emergency Housing Assistance Fund (HAF) to assist participants in finding, securing, and retaining safe, decent, and affordable housing as part of their recovery. HAF funds must be used to assist persons meeting DMHAS target population and towards securing and/or retaining market-rate leased housing. HAF must be used as a last resort. All other resources must be exhausted prior to accessing HAF. Administration and prioritization of funds will focus on Rapid Re-Housing and/or Diversion efforts outlined in the local Coordinated Access Network (CAN) process. Advanced Behavioral Health, Inc., (ABH) will serve as DMHAS's administrative service organization to process applications and issue payments on behalf of applicants. The scope of assistance/services provided by HAF may include the following rapid re-housing services:

- **Short-Term Rental Assistance (1-3 Months)** – provides rental assistance for up to three months to assist individuals in accessing safe and affordable housing.
- **Security Deposit** – provides a security deposit payment to assist individuals in securing safe and affordable housing. Security Deposits will be capped at a maximum of two months' rent and are to be kept in escrow per Connecticut rental laws. Upon the tenant's departure, Security Deposit should be returned to the applicant pursuant to the terms of the lease.
- **Ongoing Housing Assistance Fund** – provides *temporary* rental assistance directly to property owners/managers for up to six months, during which time the participant will develop and complete a plan to transition off HAF assistance. All goals must focus on achieving permanent housing and/or financial independence; appropriate steps may include placement on a wait list for subsidized housing, applying for Social Security or other permanent benefits, securing employment, obtaining a roommate or securing housing with friends or family.

The referral/application process is outlined below:

1. A DMHAS provider will review applicant's appropriateness for HAF funds. This includes current or impending homelessness (or risk thereof), engagement in DMHAS mental health and/or substance abuse services, and the status of any other assistance programs that may be available.
2. Provider staff will work with the individual and other providers if needed to locate and secure housing.
3. Provider staff will engage the individual to prepare the HAF application and gather verification of homelessness, disability, and other documentation as needed, and conduct a walkthrough of the housing unit for safety and habitability. Provider will submit application to ABH for processing, including faxing required documentation, and a review committee including DMHAS staff will make a determination and notify the requestor in writing within seven calendar days of receipt.
4. If approved, ABH will issue payments directly to property owner/manager on the applicant's behalf. Explanation(s) for denied applications will be noted on the response form and returned to the submitting provider. Written instructions regarding the appeal process will be provided to all parties involved. Reasons for denial may include the individual not meeting DMHAS target population requirements, being unable to sustain rental obligations independently, receipt of an incomplete application, or HAF budget restrictions/projections.

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APPLICATION CHECKLIST

Each of these items must be faxed to ABH at (860) 471-8124.
Incomplete submissions will result in a delay in processing.
Please check each box to confirm items have been included with application.

☐ **Release of Information (page 3)** – Attach a completed, signed copy of the included Release of Information, which allows ABH to communicate with submitting agency and property owner/manager.

☐ **Priority Assessment & Signatures (page 8)** – Select the applicant's priority level and housing status, and submit with both applicant and referrer's original signatures.

☐ **Homelessness Verification Form (page 9)** – Complete form and attach a supporting letter on agency letterhead noting the homeless status of the applicant.

☐ **Disability Verification Form (page 10)** – This form must be completed, signed, and dated by a licensed professional to provide the Axis 1 Diagnosis and/or the specific "severe" or "chronic" disability.

☐ **Financial Assessment (page 11)** – Attach written verification of income for all household members over the age of 18.

☐ **Property Owner/Manager Information (page 12), Lease, & W-9** – Complete form and attach an IRS Form W-9 completed by property owner/manager as well as a copy of the lease.

☐ **Housing Inspection Form (pages 13-19)** – Visit housing arrangement in person and complete a safety/habitability walkthrough.

PLEASE NOTE: Pages 4-7 are to be entered on the HAF Web-based application and have been included *for reference only*.

Please direct all questions regarding HAF applications to ABH, Inc.

HAF Customer Service Phone:	**(860) 704-6978**
HAF Fax Number:	**(860) 471-8124**
ABH Office Hours:	**Monday-Friday, 8:00am-5:00pm**

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Department of Mental Health and Addiction Services (DMHAS)
Housing Assistance Fund (HAF)

Consent to Disclosure and Re-disclosure of Confidential Information and Records

I,_____ DOB: , _____
(Name of Participant) (Date of Birth)

a participant in the DMHAS Housing Assistance Fund (HAF) Program, understand my support services will be coordinated through DMHAS and the DMHAS designated Administrative Service Organization (ASO). I authorize the following individuals and organizations to release and exchange information to each other for the purpose of processing Housing Assistance Fund requests:

1. The DMHAS Administrative Service Organization; and
2. _____
   [Requesting Treatment Provider/Program]
3. _____
   [Property Owner/Manager Name]
4. _____
   [Other service provider(s)

The purpose of the disclosure authorized herein is to facilitate the provision of Housing Assistance Fund services. Information exchanged may include: my name, address, age, gender, Social Security Number, clinical assessment, progress in care, the type and outcome of mental health and addiction services I have received/am currently receiving, and such other information as is necessary to provide effective coordination of the services I receive.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Chapter 899 of the Connecticut General Statues, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or statutes. I have received a summary of the federal law protecting this information and a statement of the intended use of this information. I understand that the federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, and I understand that the rules prohibiting re-disclosure to third parties without my written consent will be strictly adhered to. I also understand that I may revoke this at any time except to the extent that action has been taken in reliance on it. Unless revoked by me, this consent shall expire 30 days after signature, or:

_____
[Specific date, event or condition upon which this consent expires, only if different from above]

Date: _____ _____
[Signature of Participant or Authorized Representative where required]

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please complete and fax this form to ABH at (860) 471-8124.

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PLEASE NOTE: This page is included for reference only and will be entered in the HAF Web-based system. Do not print and fax this page to ABH.

REFERRAL SOURCE		
Agency Name:		
Street Address:		
Person Making Referral:		
Contact Information:		
	Telephone Number	Email Address

APPLICANT INFORMATION	
Name:	
Social Security Number:	
Date of Birth:	
Street Address:	
Telephone Number:	

APPLICANT DEMOGRAPHICS			
Gender:	☐ Male	☐ Female	☐ Other ☐ Prefer not to respond
Ethnicity:	☐ Hispanic	☐ Non-Hispanic	☐ Unknown
Race:	☐ White	☐ Black/African American	
	☐ Asian/Pacific Islander	☐ American Indian/Alaska Native	
	☐ Mixed or Other Race	☐ Unknown	
Marital Status:	☐ Never Married	☐ Married/Cohabitating	☐ Separated
	☐ Divorced	☐ Annulled	☐ Widowed

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HOUSEHOLD COMPOSITION List all members of the applicant's household.		
Name:	**Relationship**	**Date of Birth**

Please note that it is expected rent will be equally shared among **all** adults (18 years of age or older) in the household with the exception of married couples or adult children who can verify they are attending school. Assistance will be considered only for the applicant's portion of rent in situations where there are adult roommates or adults cohabitating.

APPLICANT EMERGENCY & ALTERNATE CONTACTS		
Emergency Contact Name:		
Telephone Number:		
Relationship to Applicant:		
Does applicant have a conservator or representative payee?	☐ Yes ☐ No	Name: Telephone Number:
Please list any other service provider contacts, such as clinicians or case managers, below.		
Name	Agency	Telephone Number

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Applicants must exhaust all other community resources prior to accessing DMHAS Emergency Housing Assistance Funds. *Please complete this section to document other resources have been exhausted before continuing.*

List all agencies/programs exhausted and a brief explanation of why they are not available. Please include any other resources that will be utilized to supplement HAF funding, including the amount of contribution.

1	
2	
3	
4	
5	

Please describe the applicant's plan to end temporary assistance. Check the appropriate box(es) and attach verification or explanation if necessary.	
☐	Applicant will be awarded Social Security benefits. *Please attach written verification reflecting status of application/appeal. Priority granted to applications submitted through SOAR.*
☐	Applicant will obtain subsidized or permanent affordable housing. *Please attach written verification of client's acceptance and number on wait list.*
☐	Applicant will gain employment and/or financial independence. *Applicant will be given no more than 6 months to secure employment.*
☐	Applicant will recruit and secure a roommate to share expenses. *Applicant will be given no more than 6 months to arrange roommate agreement.*
☐	Other *Please specify plan/steps and attach all relevant documentation.*

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PLEASE NOTE: This page is included for reference only and will be entered in the HAF Web-based system. Do not print and fax this page to ABH.

What type of assistance is the applicant requesting?				
☐	Short-Term Rental Assistance			
		☐ 1 month	☐ 2 months	☐ 3 months
☐	Security Deposit			
☐	Ongoing Housing Assistance Fund			

What is the applicant's current living situation?

How will the applicant pay for their portion of rent and/or utilities?

Although proof of sustainability is not required for approval, please explain the applicant's ability to "sustain" housing if provided HAF assistance to secure new housing. How will the applicant pay for rent once temporary assistance is no longer available?

If the applicant is chronically homeless, what efforts will be made by referring agency and/or other providers to avoid CH from occurring again?

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APPLICANT NAME: _____

ESTABLISHING PRIORITY

Priority is given to individuals applying for HAF based on their homeless status. Please indicate the homeless status of this applicant by checking the appropriate box below and include a letter (on agency letterhead) explaining the applicant's homelessness status or risk thereof.

☐ Priority # 1 — Homeless in the street, car, woods, shelter or another environment not meant for human habitation.

☐ Priority # 2 — 14 days (or fewer) away from becoming homeless. Homelessness is imminent.

☐ Priority # 3 — Tenants who have state or federal subsidy for formerly homeless persons.

LOCATING AND SECURING HOUSING

☐ Applicant is not housed and will find appropriate housing with or without the assistance of agency making the referral (ABH cannot assist individuals in locating housing).

☐ Applicant is currently housed.

SIGNATURES

_____ _____

Applicant's Signature Date

_____ _____

Referring Person's Signature Date

Please complete and fax this form to ABH at (860) 471-8124.

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HOMELESSNESS OR RISK OF HOMELESSNESS VERIFICATION

Applicant Name:		
Date Form Completed:		
Referring Agency/Program:		
Person Completing Referral:		
Contact Information:		
	Telephone Number	Email Address

This individual is currently:

- ❑ Living on the street or other (non-shelter) environment not meant for human habitation
- ❑ Living in an emergency shelter
- ❑ Fleeing a domestic violence situation and lacks the resources to obtain housing
- ❑ Being evicted within 14 days (attach copy of housing court ruling)
- ❑ A recipient of state or federal subsidy for formerly homeless persons

Please attach a letter verifying homeless status on agency letterhead, signed by agency representative.

Please complete and fax this form
to ABH at (860) 471-8124.

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DISABILITY VERIFICATION

This form must be completed and signed by a licensed mental health professional,
(e.g. Psychiatrist, Psychologist, Nurse, Social Worker, etc.)

Applicant Name:		
Person Completing Form:		
Agency:		
Contact Information:		
	Telephone Number	Email Address

TYPE OF DISABILITY	
☐	Serious Mental Illness Only
☐	Substance Abuse Only
☐	Serious Mental Illness with Co-Occurring Substance Abuse

Please use the space below to describe the applicant's Axis I diagnosis and/or severe or chronic disability.

DISABILTY ENTITLEMENT STATUS	
☐	Receives Social Security benefits
☐	Does not receive Social Security benefits
☐	Pending Social Security benefits

LICENSED PROFESSIONAL COMPLETING THIS FORM	
Signature	Title
License #	Date

Please complete and fax this form
to ABH at (860) 471-8124.

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FINANCIAL ASSESSMENT

Please attach current written verification of HOUSEHOLD income.
All persons in household over 18 years of age must supply income verification.

Social Security (SSD, SSI, SSDI)	$
SAGA or TANF cash benefits	$
Unemployment Compensation	$
Retirement, investment, or savings income	$
Rent supplement (including HUD and housing programs that receive public support)	$
Alimony and/or child support	$
Spousal income or contribution from family/friends/other household members	$
Earned income (employment)	$
Veterans Administration (VA) benefits	$
No Income	$
Other Income (please specify)	$
TOTAL HOUSEHOLD INCOME	$
SNAP benefits (not considered cash income, but please answer if applicable)	$

Please fax written verification of all income noted above to ABH at (860) 471-8124.

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PROPERTY OWNER/MANAGER INFORMATION

Name:	
Owner/Manager's Street Address	
Telephone Number:	
Rental Unit Street Address*:	
Apartment Size (Number of Bedrooms):	
Monthly Rent Amount:	
Security Deposit:	
Applicant Name:	

*** This apartment must be inspected by requesting agency prior to tenant move-in.**

Note: A W-9 Form completed by the property owner/manager and a copy of the lease must be attached to this application. A blank W-9 form can be found at https://www.irs.gov/pub/irs-pdf/fw9.pdf.

Please complete and fax this form
to ABH at (860) 471-8124.

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This form must be completed by staff of the referring agency after an in-person visit of the housing arrangement.

A. GENERAL INFORMATION			
Applicant Name:			
Date of Inspection:			
Street Address:			
Type of Home: (check one)	☐ Single Family ☐ Low-Rise (3-4 stories) ☐ Row House/Town House ☐ Congregate ☐ Other (please specify:	☐ Duplex/Two-Family ☐ High-Rise (5+ stories) ☐ Mobile Home ☐ Cooperative	
Type of Inspection:	☐ Move In	☐ Move Out	☐ Annual

Proceed through the inspection as follows:

Checklist Category
B. Living Room
C. Kitchen
D. Bathroom
E. All Rooms Used For Living
F. All Other Rooms Not Used for Living
G. General Health and Safety

Each section of the checklist will be accompanied by an explanation of the item to be inspected.

In the space to the right of the description of the item, if the decision on the item is "Fail," describe in detail any necessary repairs or items to be replaced (if possible, please record reason for repairs – i.e., ordinary wear & tear, tenant damage, etc.). Also, if item is marked to "Pass" but there are additional code items or items not consistent with standards or area codes, write these in the space to the right as well. This form should serve to establish the condition of the unit, indicate any areas to negotiate with the property owner/manager, and aid in assessing the reasonableness of rent. The applicant is responsible for deciding whether they find these conditions acceptable.

Please complete and fax this form to ABH at (860) 471-8124.

B. LIVING ROOM				
Item #	**Description**	**Decision**		**Repairs Required**
1.1	LIVING ROOM PRESENT Is there a living room?	☐ Pass	☐ Fail	
1.2	ELECTRICITY Are there at least two working outlets OR one working outlet and one light fixture?	☐ Pass	☐ Fail	
1.3	ELECTRICAL HAZARDS Is the room free from electrical hazards?	☐ Pass	☐ Fail	
1.4	SECURITY Are all accessible windows and doors lockable?	☐ Pass	☐ Fail	
1.5	WINDOW CONDITION Are all windows free of signs of severe deterioration?	☐ Pass	☐ Fail	
1.6	CEILING CONDITION Is the ceiling free from hazardous defects?	☐ Pass	☐ Fail	
1.7	WALL CONDITION Are the walls sound and free from hazardous defects?	☐ Pass	☐ Fail	
1.8	FLOOR CONDITION Is the floor sound and free from hazardous defects?	☐ Pass	☐ Fail	
1.9	LEAD PAINT Are all of the interior surfaces free of cracking, scaling, peeling, chipping, or loose paint?	☐ Pass	☐ Fail	

Notes (Reference Item #):

C. KITCHEN

Item #	Description	Decision		Repairs Required
2.1	KITCHEN AREA PRESENT Is there a kitchen?	☐ Pass	☐ Fail	
2.2	ELECTRICITY Are there at least two working outlets OR one working outlet and one light fixture?	☐ Pass	☐ Fail	
2.3	ELECTRICAL HAZARDS Is the room free from electrical hazards?	☐ Pass	☐ Fail	
2.4	SECURITY Are all accessible windows and doors lockable?	☐ Pass	☐ Fail	
2.5	WINDOW CONDITION Are all windows free of signs of severe deterioration?	☐ Pass	☐ Fail	
2.6	CEILING CONDITION Is the ceiling free from hazardous defects?	☐ Pass	☐ Fail	
2.7	WALL CONDITION Are the walls sound and free from hazardous defects?	☐ Pass	☐ Fail	
2.8	FLOOR CONDITION Is the floor sound and free from hazardous defects?	☐ Pass	☐ Fail	
2.9	LEAD PAINT Are all of the interior surfaces free of cracking, scaling, peeling, chipping, or loose paint?	☐ Pass	☐ Fail	
2.10	STOVE OR RANGE WITH OVEN Is there a working oven or microwave oven and a stove with top burners that work?	☐ Pass	☐ Fail	
2.11	REFRIGERATOR Is there a refrigerator that works and maintains a temperature low enough so that food does not spoil?	☐ Pass	☐ Fail	
2.12	SINK Is there a sink with hot and cold running water?	☐ Pass	☐ Fail	

Notes (Reference Item #):

D. BATHROOM				
Item #	**Description**	**Decision**		**Repairs Required**
3.1	BATHROOM Is there a bathroom?	☐ Pass	☐Fail	
3.2	ELECTRICITY Are there at least two working outlets OR one working outlet and one light fixture?	☐ Pass	☐Fail	
3.3	ELECTRICAL HAZARDS Is the room free from electrical hazards?	☐ Pass	☐Fail	
3.4	SECURITY Are all accessible windows and doors lockable?	☐ Pass	☐Fail	
3.5	WINDOW CONDITION Are all windows free of signs of severe deterioration?	☐ Pass	☐Fail	
3.6	CEILING CONDITION Is the ceiling free from hazardous defects?	☐ Pass	☐Fail	
3.7	WALL CONDITION Are the walls sound and free from hazardous defects?	☐ Pass	☐Fail	
3.8	FLOOR CONDITION Is the floor sound and free from hazardous defects?	☐ Pass	☐Fail	
3.9	LEAD PAINT Are all of the interior surfaces free of cracking, scaling, peeling, chipping, or loose paint?			
3.10	FLUSH TOILET IN ENCLOSED ROOM Is there a working toilet for private use of the tenant?	☐ Pass	☐Fail	
3.11	FIXED WASH BASIN Is there a working wash basin with hot and cold running water?	☐ Pass	☐Fail	
3.12	BATHTUB OR SHOWER IN UNIT Is there a working bathtub or shower with hot and cold running water?	☐ Pass	☐Fail	
3.13	VENTILATION Is there a working vent system or a window that can open?	☐ Pass	☐Fail	

Notes (Reference Item #):

E. ALL ROOMS USED FOR LIVING (attach multiple sheets if needed)

Occupancy Standard: Count the number of rooms used for sleeping (or potentially used for sleeping) identified below and record here: _____

Item #	Description	Decision		Repairs Required
4.1	ROOM CODE and ROOM LOCATION: right/left _____ front/rear _____ floor level _____	ROOM CODES 1 = Bedroom or any other room used for sleeping (regardless of actual type of room) 2 = Dining Room, or Dining Area 3 = Second Living Room, Family Room, Den, TV Room 4 = Entrance Halls, Corridors, Halls, Staircases 5 = Additional Bathroom 6 = Other		
4.2	ELECTRICITY If Room Code = 1, are there at least two working outlets OR one working outlet and one light fixture? If Room Code does not = 1, is there a means of illumination?	☐ Pass	☐ Fail	
4.3	ELECTRICAL HAZARDS Is the room free from electrical hazards?	☐ Pass	☐ Fail	
4.4	SECURITY Are all windows and doors that are accessible from the outside lockable?	☐ Pass	☐ Fail	
4.5	WINDOW CONDITION Are all windows free of signs of severe deterioration?	☐ Pass	☐ Fail	
4.6	CEILING CONDITION Is the ceiling free from hazardous defects?	☐ Pass	☐ Fail	
4.7	WALL CONDITION Are the walls sound and free from hazardous defects?	☐ Pass	☐ Fail	
4.8	FLOOR CONDITION Is the floor sound and free from hazardous defects?	☐ Pass	☐ Fail	

Notes (Reference Item #):

F. ALL OTHER ROOMS NOT USED FOR LIVING (attach multiple sheets if needed)				
Item #	**Description**	**Decision**		**Repairs Required**
5.1	NONE. GO TO SECTION G	☐ Pass	☐ Fail	
5.2	SECURITY Are all accessible windows and doors lockable?	☐ Pass	☐ Fail	
5.3	ELECTRICAL HAZARDS Are all rooms free from electrical hazards?	☐ Pass	☐ Fail	
5.4	OTHER POTENTIALLY HAZARDOUS FEATURES IN ANY OF THESE ROOMS Are all of these rooms free of any other potentially hazardous features? For each room with an "other potentially hazardous feature" explain hazard and means of control of interior access to room.	☐ Pass	☐ Fail	

Notes (Reference Item #):

G. GENERAL HEALTH AND SAFETY				
Item #	**Description**	**Decision**		**Repairs Required**
6.1	ACCESS TO UNIT Can the unit be entered without having to enter or go through another unit?	☐ Pass	☐ Fail	
6.2	EXITS Is there a fire exit from the unit that is not blocked?	☐ Pass	☐ Fail	
6.3	REFUSE DISPOSAL Are there adequate covered facilities for the disposal of food wastes?	☐ Pass	☐ Fail	
6.4	INTERIOR/EXTERIOR STAIRS OR HALLWAYS Are interior/exterior stairs and common halls free from hazards?	☐ Pass	☐ Fail	
6.5	ELEVATORS If there is an elevator, is a current inspection certificate visible?	☐ Pass	☐ Fail	
6.6	SMOKE DETECTORS Is there at least one working smoke detector on each floor?	☐ Pass	☐ Fail	

Notes (Reference Item #):

H. SUMMARY DECISION ON UNIT	
☐ FAIL	If there are any checks under the column labeled "Fail," this unit does not meet minimum housing standards. Discuss with the property owner/manager repairs noted that would bring the unit up to standard and schedule a revisit.
☐ PASS	If there are no checks under the column labeled "Fail," this unit meets minimum housing standards.

Name of Person Completing Inspection (please print)

Signature of Person Completing Inspection