DMHAS HOUSING & HOMELESS SERVICES UNIT
HOUSING STABILIZATION SERVICES

The Department of Mental Health and Addiction Services (DMHAS) developed the Housing Stabilization Services (HSS) Program to assist participants in securing or maintaining safe, decent, and affordable housing as part of their recovery. HSS funds must be used to assist persons experiencing homelessness or housing instability. Advanced Behavioral Health, Inc., (ABH) will serve as DMHAS's administrative service organization to process applications and issue payments on behalf of applicants. HSS assistance may include the following services:

- **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.

- **Utility Assistance** – provides payment directly to utility service vendors in order to assist individuals in securing and maintaining safe and affordable housing. Please note this is not intended to cover ongoing utility supports.

HSS service approvals are limited to *a combined maximum of $5,000 per person* for the life of the program.

If approved, ABH will issue payments directly to property owner/manager or utility vendor on the applicant's behalf. Explanation(s) for denied applications will be noted on the response form and returned to the submitting provider. 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 HSS budget restrictions/projections.

Agencies who wish to submit HSS applications on behalf of eligible clients must submit a Login Request Form (available at https://www.abhct.com/Programs_Services/DMHAS-Housing-Assistance-Fund-HAF-/) to ABH at (860) 471-8124. Please review the User Manual on the Forms & Resources page for more information and note that some pages of the application must be printed, signed, and faxed to ABH as indicated below.

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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.

☐ **Client Application for Utility Supports to Exit Homelessness or Maintain Housing (page 3)** – Attach a complete, signed copy of the client application; this includes a complete, legible copy of the most recent utility bill and/or notice of termination and verification of income (please do not fax photos).

☐ **Release of Information (page 5)** – Attach a completed, signed copy of the included Release of Information, which allows ABH to communicate with submitting agency.

PLEASE NOTE: Page 4 (Applicant Statements) is to be entered on the HSS Web-based application and has been included *for reference only*.

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

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

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Client Application for Utility Supports to Exit Homelessness or Maintain Housing

INITIAL ELIGIBILITY REQUIREMENTS

Clients admitted into any DMHAS-funded program who are experiencing homelessness or housing instability

APPLICANT'S NAME: _____ DATE: _____

Social Security#: _____-_____-_____ D.O.B: ____ / ____ / _____

Gender: [ ] Male [ ] Female **Ethnicity:** [ ] Hispanic [ ] Non-Hispanic [ ] Unknown

Race: [ ] White [ ] Black/African American [ ] Asian/Pacific Islander

[ ] American Indian/Alaskan Native [ ] Mixed or Other Race [ ] Unknown

Marital Status: [ ] Never Married [ ] Married/Cohabiting [ ] Separated [ ] Divorced

[ ] Annulled [ ] Widowed [ ] Other [ ] Unknown

Total household gross monthly income (attach verification): _____

Total household monthly expenses: _____

Please fill in the utility vendor and amount requested below. HSS assistance is limited to $5,000 per person for the life of the program. Please fax a complete copy of the most recent utility bill and/or notice of termination – this should be in the applicant's name and the total due, payment address, and account number must be clearly visible.

Utility: _____ Amount Requested: $ _____

Utility: _____ Amount Requested: $ _____

Referring Agency: _____

Person making referral: _____ Title: _____

Phone #: _____ Email: _____

APPLICANT'S SIGNATURE: _____ DATE: _____

REFERRING AGENCY STAFF SIGNATURE: _____ DATE: _____

Please note – original signatures are required, and electronic signatures are not accepted. Please complete and fax this form to ABH at (860) 471-8124.

Client Application for Utility Supports to Exit Homelessness or Maintain Housing

APPLICANT STATEMENTS

Please ask applicant to answer the questions below.
These responses will be entered onto the HSS Web-based system.
Do not print and fax this page.

Please describe your current living situation.

Please describe how receiving Housing Stabilization Services will benefit your homelessness situation or housing instability:

Please describe your job searches and/or vocational program, or tell us if you're working or have other income or benefits:

Please explain how your rent and utilities will be paid on an ongoing basis:

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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 Stabilization Service (HSS) 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 HSS 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 Stabilization 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