**The Opportunity Alliance**

**50 Lydia Lane, South Portland, ME 04106**

[www.opportunityalliance.org](http://www.opportunityalliance.org)

Submit Application to:

[wrapapplication@opportunityalliance.org](mailto:wrapapplication@opportunityalliance.org)

or Fax to 207-874-1181

**For Agency Use Only**

|  |  |
| --- | --- |
| Date Received |  |
| Application Complete |  |
| Application Incomplete |  |

**Adult Mental Health**

**Wrap-fund Application**

**Cumberland County**

***All Wrap-fund applications submitted must be legible, in black or blue ink, and completed with all required information. A Wrap-fund application submitted and not completed shall be marked incomplete and returned to the Applicant to resubmit.***

Date of Application:

Applicant Name: Applicant SSN:

Address:

City: Zip Code:

County: Telephone Number:

Mailing Address, if different:

Please complete, if applicable:

Applicant’s Provider Agency:

Case Manager Name: Phone:

Address:

Email:

Do you have a Representative Payee? Yes  No  If Yes, please provide:

Name:

Agency:

Phone Number: Email:

I certify and attest that the attached information is true and complete to the best of my knowledge and belief.

***Name of Applicant/Consumer whom Wrap funds are being applied for:***

Name:

Applicant/Consumer Signature:

***Name of Agency and Representative:***

Agency Name:

Agency Representative Name:

Agency Representative Signature:

**SECTION 1 - ELIGIBILITY**

Applicant must meet the Eligibility for Care requirements as stated in 10-144 C.M.R. ch.101 § 17.02. These requirements must be verified and attested to by a clinician through a signature on the application **OR** authorization by KePro CareConnection®;

Is Applicant currently enrolled in Adult Mental Health Services funded Community Support (Section 17)?

Yes  No. If Yes, Applicant’s Case Manager should complete the **Verification of Current Section 17 Services** section and attach copy of the authorization by KePro CareConnection® to verify enrollment.

* If No, please complete **Section 17 Eligibility Form** on the next page.

**Verification of Current Section 17 Services**

1. I hereby affirm the information included below concerning the current situation, current address, and eligibility criteria are true and accurate for this client in the Section 17 eligibility form and application.
2. I verify the Applicant meets the Eligibility for Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual.

Case Manager must sign below, and verification of enrollment with KePro CareConnection® attached to application. **Continue to SECTION 2 – FINANCIAL.**

|  |
| --- |
| Referring Agency: |
| Printed Name: |
| Signature: |
| Date: |

**Section 17 Eligibility Form to be completed only for Applicants that are not already in Section 17 services.**

*A clinician is an individual appropriately licensed or certified in the state or province in which he or she practices, practicing within the scope of that licensure or certification, and qualified to deliver treatment under this Section. A qualified professional with one of the following credentials: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker-conditional (LMSW-conditional clinical); physician; psychiatrist; Psychiatric and Mental Health Nurse Practitioner (PMH-NP); Psychiatric and Mental Health Clinical Nurse Specialists (PMH-CNS); Adult Nurse Practitioner (ANP); Family Nurse Practitioner (FNP); Physician Assistant (PA); or licensed psychologist****.***

I hereby affirm the below-enclosed information concerning the current situation, current address, and eligibility criteria are true and accurate for this client in the Wrap Section 17 eligibility form and application.

1. I verify the Applicant meets the Eligibility for Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual.

|  |  |
| --- | --- |
| **Client Information** | **Diagnosis Information** |
| Name: | Primary Diagnosis: |
| Date of Birth: | Date Given: |
| Social Security number: |  |

**Specific Eligibility Requirements**.

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

1. 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:

* + - 1. 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

1. Has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
2. 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
3. Has been committed by a civil court for psychiatric treatment as an adult; or
4. Until the age of twenty-one (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 twelve (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

1. Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the LOCUS, ANSA, 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.
2. 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.

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

**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.

History Of (check all which apply):

has received treatment in a state psychiatric hospital, within the past twenty-four (24) months;

has been discharged from a mental health residential facility, within the past twenty-four (24) months;

has had two (2) or more episodes of inpatient treatment for mental illness, for greater than seventy-two (72)

hours per episode, within the past twenty-four (24) months;

has been committed by a civil court for psychiatric treatment as an adult;

until the age twenty-one (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

Require a mental health inpatient treatment greater than 72 hours

Residential treatment unless community support is provided

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 attached verifications, diagnostic information including LOCUS score and/or ANSA score are in accordance with 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.

**Clinician Signature/Credentials** **Date**

(LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; physician; psychiatrist; Psychiatric and Mental Health Nurse Practitioner (PMH-NP); Psychiatric and Mental Health Clinical Nurse Specialists (PMH-CNS); ANP; FNP; PA; or licensed psychologist.)

**Printed Name and Credentials**

**SECTION 2 - FINANCIAL**

*Each Wrap-fund application includes all household income, assets and benefit resources.*

What is your current household monthly income?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | **Applicant** | **Family**  **Member 1** | **Family**  **Member 2** | **Family**  **Member 3** |
| Social Security Income | $ | $ | $ | $ |
| Public Assistance Payments  (TANF, GA, LIHEAP, etc.) | $ | $ | $ | $ |
| Employment | $ | $ | $ | $ |
| Rent Paid by Housing Subsidy (BRAP, Shelter Plus Care, Section 8, etc.) | $ | $ | $ | $ |
| Child Support | $ | $ | $ | $ |
| Alimony Received | $ | $ | $ | $ |
| Worker’s Compensation | $ | $ | $ | $ |
| Other Income: | $ | $ | $ | $ |
| **TOTAL** | $ | $ | $ | $ |

**GRAND TOTAL OF ALL FAMILY MEMBERS INCOME** $ (Add total of Applicant + family members)

* If no monthly income is reported, please explain this circumstance:

Do you receive Food Stamps? Yes  No  Amount: $

Do you receive Section 8 or some other Housing Subsidy? Yes  No  . If No, are you on a waitlist?

Yes (Agency: Please Add Housing Subsidy Agency Here

No

**VETERANS BENEFITS** (Does not impact eligibility for Wrap funds - *this section is meant to inform Applicant of other potential sources of assistance if Applicant or other household member has served in the Military*)

Did you or anyone in your household serve in the US Military? Yes  No

If Yes, please answer the following questions for each individual:

|  |  |  |  |
| --- | --- | --- | --- |
| Question  1 | Name of Individual in household who served in the military | Branch of the military served | Dates of Service  (Start Date – End Date) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Question 2 | Have you or anyone in your household ever applied for VA benefits?  Yes  No |
| 2a | If No, would you like help from the Maine Veterans’ Service to apply for VA benefits? Yes  No |
| 2b | If Yes, please complete a Authorization to Release Information form from your Case Management Agency to authorize (Insert Agency Name) to release information to “Maine Veterans’ Service”. |

What are your current household monthly expenses? (For housing requests, describe the expenses at the new housing)

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Household Expenses** | **Category** | **Household**  **Expenses** |
| Amount of rent paid by Applicant for Rent/Mortgage Payment/Lot Rent |  | Other Necessary Expenses (list): |  |
| Alimony Paid |  |  |  |
| Child Support Paid |  |  |  |
| \*Transportation Expense |  |  |  |
| \*\*Heating Expense |  |  |  |
| \*\*Electric Expense |  |  |  |
| \*\*Water & Sewer |  |  |  |
| Telephone/ Cell Phone /Internet/ Cable (circle) |  |  |  |
| **Total** |  | **Total** |  |

**GRAND TOTAL OF ALL HOUSEHOLD EXPENSES:** $ (Add both Household Expense columns)

**\* Transportation** expenses include payment, fuel, maintenance, inspections/tags, and insurance.

**\* Public** *transportation can be listed under other necessary expenses.*

**\*\*** If heating, electric, water and sewer is included in rent, write **INCLUDED**.

If no monthly expense is reported, please explain this circumstance:

Are you behind in any of your bills? Yes  No . If Yes, please explain:

**Verification of Other Resources** (e.g., General Assistance, Section 8 housing, LHEAP, Salvation Army, Religious Organizations, etc.):

Must list other resources you have tried. List name of organizations/agencies/resources, name of person you spoke with, phone number, date of interaction, and outcome (approval or denial to receive resource.

|  |  |  |
| --- | --- | --- |
| **Organization/Contact** | **Phone Number** | **Outcome of Request** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**SECTION 3 – REQUEST FOR ASSISTANCE**

Is this an emergency need? Yes  No

If **NO**, you are not eligible for Wrap funds.

If **YES**,

1) Please provide as much detail as possible as to why you are requesting Wrap funding, and

2) Explain how this will resolve the emergency need.

*Use an additional sheet and attach to application if needed.* The requests are reviewed by Wrap-fund committees that do not know you and your circumstances behind the need. The most current and concise information you can provide will be helpful.

**SECTION 3 – REQUEST FOR ASSISTANCE *continued***

**Applicant to complete Wrap-fund Category. Please select category and include amount of request and any other required documents.**

**Applicant must provide Vendor Tax ID with Wrap Application**

\*If the Security Deposit, Rent Assistance or Temporary Housing in a Motel exceeds over $500.00, any amount over will make up the total allowance for the Applicant for state fiscal year of July 1, 2018–June 30, 2019.

Applicant cannot apply for Wrap funds until the start of the next state fiscal year, July 1, 2019.

\*\* Funds may be used for more than one (1) need below but cannot exceed $500.00 per State fiscal year per Applicant for Non-Housing Assistance.

**Note: In order to request Wrap funding for Temporary Housing in a motel, the Wrap applicant must meet the Eligibility for Care requirements as stated in 10-144 C.M.R. ch.101 § 17.02 and must have a Community Integration Worker (Case Manager) or a PATH Navigator working with the applicant. These requirements must be verified and attested to by a clinician through a signature on the application OR authorization by KePro Atrezzo®.**

\***Security Deposit** (*must provide Security Deposit Agreement Form;* not to exceed one month’s Fair Market Rent as published by the U.S. Department of Housing and Urban Development)

1) Applicant must demonstrate they have, or are in the process of applying for State, Federal, local housing

subsidies, General Assistance and/or Bridging Rental Assistance Program (BRAP) to show efforts are being

made to obtain permanent, safe and stable housing.

Please provide amount of rent paid by Applicant $ and amount of rent paid by subsidy program$

If none, what are the sources of income to pay rent:

# of bedrooms City/town of housing

\***Rent Assistance** (*must provide eviction notice or documentation of what is currently owed*; not to exceed one

month’s Fair Market Rent as published by the U.S. Department of Housing and Urban Development)

Please Note:

1) Wrap can fund Applicant/tenant portion of their rent equal to or less than one month’s FMR value.

2) These funds can pay for Applicant/tenant portion of back rent owed equal to or less than one month’s total

rent FMR value. This will allow for Applicant’s back rent to be funded by Wrap equal to or less than FMR but

would not be restricted to one month’s rent.

3) The Wrap Applicant is required to provide documentation on the Wrap application that their tenant portion is

equal to or less than one-month FMR, if they receive a housing subsidy, and can demonstrate/document that

this will be a permanent resolution.

4) Applicant must demonstrate they have, or are in the process of applying for all State, Federal, local housing

subsidies, General Assistance, and/or Bridging Rental Assistance Program(BRAP) to show efforts are being

made to obtain permanent, safe and stable housing.

Please provide amount of rent paid by Applicant $ and amount of rent paid by subsidy program $

If none, what are the sources of income to pay rent:

# of bedrooms City/town of housing

\*\***Temporary Housing in a Motel**

Criteria 1-5 must be verified by consumer and/or 3rd party.

1) Applicant is homeless, and/or Applicant has been denied access to homeless shelter.

2) Applicant has behavioral and/or physical health issues which prohibits staying at a homeless shelter.

3) Applicant must provide two (2) hotel rates from area motels.

4) Temporary housing may not exceed two (2) weeks unless approved by the Department.

5) Applicant must demonstrate they have or are in the process of applying for State, Federal, local housing subsidies, General Assistance and/or Bridging Rental Assistance Program (BRAP) to show efforts are being made to obtain permanent, safe and stable housing.

6) Must have a Community Integration Worker (Case Manager) or a PATH Navigator working with the applicant.

**­­­Note:** **In order to request Wrap funding for Temporary Housing in a motel, the Wrap applicant must meet the Eligibility for Care requirements as stated in 10-144 C.M.R. ch.101 § 17.02 and must have a Community Integration Worker (Case Manager) or a PATH Navigator working with the applicant. These requirements must be verified and attested to by a clinician through a signature on the application OR authorization by KePro Atrezzo®.**

\***Prescribed Medications** (up to a two (2) week supply)

1. Applicant must attach copy of the prescription with Applicant’s name signed by the prescriber with the Wrap-fund application.
2. Applicant must attach a pharmacy bill to the Wrap-fund application.

**\*Electric Bill** to maintain power in the Applicant’s residence or prior electric bill if this allows the Applicant to

move to a permanent, stable and safe housing. (Wrap-funds can only be applied to one electric bill.)

1. The Applicant must provide a copy of the disconnect notice and attach it to the Wrap-fund application with the amount of payment required to prevent disconnection of power.
2. The Applicant must provide a copy of an approved payment plan from power vendor for remaining amount and attach to the Wrap-fund application.
3. The Applicant must provide a copy of the prior electric bill with Applicant’s name and supporting documentation that past due electric bill is preventing the Applicant from moving into a permanent, safe and secure housing.
4. Applicant to verify that it is the Applicant’s obligation to pay for electric bill under a lease/occupancy Agreement under the Applicant’s name.

\***Emergency Fuel** (one hundred (100) gallons, or one hundred (100) pounds lbs. of propane, or one (1) cord of

Wood – Please attach fuel bill)

1) Applicant must verify they have an appointment for fuel assistance and/or or must be actively applying for State, Federal and town heating assistance programs.

2) Applicant to verify that it is the Applicant’s obligation to pay for fuel under a lease/occupancy Agreement under the Applicant’s name.

\***Vision /Eye Care**-not to exceed $250.00 (Please attach eye glass prescription, estimate and/or bill for eye glasses

in Applicant’s name from the provider)

\***Oral/Dental Care**-not to exceed $250.00 (Please attach Oral/Dental Care estimate and/or bill in Applicant’s

name from the provider)

**\*Denture Care**-not to exceed $500.00 (Please attach prescription for dentures by MD in the Applicant’s name,

medical reason, estimate and/or bill in Applicant’s name for dentures from the provider)

\***Transportation to Include Car Repairs and Transportation to Access Mainstream Services**-not to exceed

$250.00 (Please attach estimate of repair cost).

1) Please attach car repair estimate from certified car mechanic. Car repairs can be completed by consumer ‘s

choice of vendors.

2) Provide documentation that transportation is needed to access a Mainstream Resource, length of time

transportation is needed, mileage and cost of transportation to include (2) estimates.

3) Provide documentation that MaineCare will not cover cost of transportation to Mainstream Resource.

\***Other Emergency Need**-not to exceed $250.00 (Please attach estimate)

Please describe “Other Emergency Need”:

\***Emergency Need as referred by the Department**

***Wrap-fund amount requested by Applicant $***

*Please complete either Security Deposit Agreement (page 14) or Vendor Information page for non-security deposit requests (page 15).*

*For all applications, please attach completed W-9 from vendor/landlord.*

**SECTION 4 – APPLICANT AND COMMITTEE CHECKLIST**

For each application, the **Wrap-fund Applicant and Committee** must answer **“YES”** to the following five (5) criteria for Wrap funds to be approved:

|  |  |
| --- | --- |
| Does the Applicant verify that the need for Wrap funds is an emergency (an urgent need requiring financial aid)? | Yes  No |
| Do Wrap funds create a resolution to this emergency need? | Yes  No |
| Has the Applicant verified that they have applied for all Federal, State and community subsidies? | Yes  No |
| Does the Applicant’s current household budget and income plan reflect that they are living within their financial means? | Yes  No |
| Does the Wrap-fund request fall under the Wrap-fund emergency need and allowable amount? | Yes  No |

**Note**: All approved application requests for Wrap funds must fall under the following Wrap-fund needs and Wrap-fund Allowable Amounts as described in SECTION 3 above.

Wrap funds can be used within the State fiscal year of July 1, 2018 –June 30, 2019.

**Wrap Funding will not pay for:** telephone or cell phone payments; vehicle payments; vehicle insurance; vehicle registration; cable bills; mental health services; any legal services/representation; additional funding stream for contracting agencies; pet related expenses; Court ordered DEEP or offender treatment; purchasing computers; car repairs which exceed sixty percent (60%) of the vehicle’s Kelley Blue Book value, or when other transportation resources are available; debt consolidation or credit counseling services; and internet services.

**The Opportunity Alliance (TOA)**

**SECURITY DEPOSIT AGREEMENT**

**For Security Deposits only: Must be signed by new Landlord**

|  |  |
| --- | --- |
| **Landlord** | **Tenant** |
| Business Name: | Name: |
| Business Address: | Address of Leased Premises: |
| Tax ID or SSN Required: | Number of Bedrooms at Rented Location: |

|  |  |
| --- | --- |
| MONTHLY RENT: | $ |
| TOTAL SECURITY DEPOSIT: | $ |
| TOA PORTION OF SECURITY DEPOSIT: | $ |

* Please note: TOA portion of the Security Deposit is dependent upon the applicant’s Wrap application being approved.
* In consideration of the Landlord's leasing residential premises to Tenant as above indicated and the Landlord's following agreements concerning the security deposit, TOA is willing to pay the indicated TOA portion of the security deposit. Landlord therefore agrees as follows:

The TOA portion of the security deposit shall in all respects be subject to the provisions of Maine law governing residential security deposits, 14 MRSA §§ 6031-6039. Without limiting the foregoing, Landlord shall treat the TOA portion of the security deposit as provided in 14 MRSA §§ 6035 and 6038 during the tenancy and upon any termination of Landlord's interest in the leased premises. Landlord shall promptly notify TOA in writing of any termination of the lease or of Tenant's habitation of the leased premises and shall return the TOA portion of the security deposit to TOA within thirty (30) days after the date Tenant vacates the leased premises, subject only to amounts Landlord may lawfully retain due to nonpayment of rent or physical damage to the leased premises beyond normal wear and tear. In the event any amounts are so retained, Landlord shall within that thirty (30) day period provide TOA a written itemization of all amounts charged against the security deposit together with payment of any remaining balance of the TOA portion of the security deposit after application of the itemized retentions. In no event shall TOA be liable for any damages, costs or claims of any kind under the lease either in excess of the TOA portion of the security deposit or arising from reasons other than those which may lawfully be applied to retention of a security deposit for residential premises.

**AGREED BY LANDLORD:** By:

|  |
| --- |
| Signature and Title: |
| Date: |
| Printed Name: |
| **\*Please complete this form as well as a W-9.** |

**VENDOR INFORMATION FOR ALL REQUESTS THAT ARE NOT SECURITY DEPOSITS:**

|  |
| --- |
| Check Payable To: |
| Mailing Address: |
| Phone Number: |
| Federal Tax ID # or Social Security Number: |