CRISIS HOUSING FUND for Persons with a Serious Mental Illness

Funded through the Minnesota Department of Human Services (DHS)

*** Must be completed by the Applicant Agency ***

Disbursement of funds will not be made without a signed original application.

1) PROGRAM DESCRIPTION

The Crisis Housing 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 or residential treatment of 90 days or less.

2) ELIGIBILITY

- Persons with a serious mental illness. (*See mental illness definition on Crisis Housing Fund website at http://mhponline.org/crisis-housing)*
- Persons with community-based housing (rental or ownership).
- Persons of low or moderate income, as determined by HUD. See income limits at http://www.mhponline.org/crisis-housing/eligibility
- Persons admitted to a mental health treatment facility (includes a facility for chemical dependency) and receiving treatment for 90 days or less.
- Persons applying from community hospitals should be assisted with a referral for mental health case management services.

3) CLIENT INFORMATION	4) TREATMENT FACILITY INFORMATION
Full Name:	Treatment Facility:
Date of Birth (mm/dd/yyyy):	Street Address:
Social Security #:	City/County: /
Street Address:	Tribe: (If Applicable)
City/County: /	Zip:
Tribe: (If Applicable)	Phone:
Zip:	Dates of Treatment Start: End:
Email Address:	Select Months with Expenses (up to 3) 1) N/A 2) N/A 3) N/A
Monthly Household Income:$	Sources of Income:
Household Size:	Number of Adults: Number of Dependents:
Is client living in subsidized housing? ◯ Yes ◯ No	

5) ELIGIBLE COSTS

- Covers monthly 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).
- Eligable Fees include Lot fees, Condo Association Dues
- Funds only cover the retention of the client's current housing and cannot be used for damage deposit or down-payment.

6) INELIGIBLE COSTS

- 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 or expenses occuring outside of the treatment period.

7) REQUESTED FINANCIAL ASSISTANCE

Select one: ◯ Rent ◯ Mortgage	$
Fees (list): _____	$
Electricity:	$
Heating:	$
Garbage:	$
Water/Sewer:	$
Phone (Maximum of $25/month):	$
Other (list):	$
MONTHLY TOTAL:	**$**
# OF MONTHS:	
REQUEST TOTAL:	**$**

8) PAYMENT INFORMATION

- Payments can only be made to the Applicant Agency, Client's Property Management Company, or a Rep Payee Organization.
- **Payments will NOT be made to individuals.**
- Payment will be issued within 5 working days of approval of the application. The application must be complete, including the client's original signature, and all se This includes the client's original signature and all 7 Applicant Certifications initialed. **Photocopied Apps Not Accepted.**

Make Check Payable to (check one): ☐ Applicant Agency* ☐ Other**

Mail Check to (check one): ☐ Applicant Agency* ☐ Other**

* Must complete section 10 ** Must complete section 10 and section 11

9) APPLICANT AGENCY REQUEST FOR ADMINISTRATIVE FEE	INITIAL
Initial here to request a $40 administrative fee for reissuing housing assistance payment(s) on the applicant's behalf.	

10) APPLICANT AGENCY INFORMATION	11) PAYMENT ADDRESS (if different than Applicant Agency)
Agency Name:	Make Check Payable to:
Street Address:	Street Address:
City/County: /	City/County: /
Zip:	Zip:
Phone:	Phone:
Agency Type:	Relation to Client:

**** NOTE: Crisis Housing Funds cannot be disbursed directly to the client or client's family member (unless family member is a legal custodian) ****

12) APPLICANT AGENCY CONTACT INFORMATION		
Full Name of Agency Signee:	Phone:	Email:
Supervisor:	Phone:	Email:
HR Dept. Contact:	Phone:	Email:
Organizational Website:		

13) APPLICANT AGENCY CONTACT CERTIFICATIONS	INITIAL
Applicant Agency is a government unit, nonprofit corporation, Indian Tribe, Health Plan Representative, Behavioral Health Home or mental health service provider.	
The household of the client qualifies as "low" or "moderate" income as defined by the U.S. Dept. of Housing and Urban Development.	
The client has been diagnosed with a serious mental illness, and has been admitted to the treatment facility above for inpatient or residential mental health or chemical dependency treatment, not to exceed ninety (90) days duration.	
Crisis Housing Funds will only be used to retain current housing while an individual is receiving mental health treatment.	
The household of the client has no other resources from which to pay the housing-related expenses listed above AND that the client will be able to pay rent, mortgage, and/or utilities when they return to their community housing.	
The Applicant Agency agrees to maintain records of Crisis Housing Fund use for a period of three (3) years, and to make records available to the Minnesota Department of Human Services, as the State of Minnesota sponsoring agency.	
The Applicant Agency agrees to name the Minnesota Department of Human Services as a co-insurer on its crime insurance policy. Any and all fraudulent activity by the Applicant, Applicant Agency, or landlords is the sole responsibility of the Applicant Agency.	

14) APPLICANT AGENCY CONTACT SIGNATURE

I certify that all the information contained in this form is accurate to the best of my knowledge. (Please sign in BLUE ink)

Signature of Applicant Agency Contact: **Date:**

See next page for client signature and Consent to the Release of Information.

15) CONSENT TO THE RELEASE OF INFORMATION

The Information being requested above is private. The use of this information is controlled by law. Minnesota Government Data Practices Act, M.S. Chapter 13

- Information is being released from the facility listed above to the Department of Human Services and the Crisis Housing Fund.
- Types of information being requested:
  1) Verification of in-patient/residential psychiatric or chemical dependency treatment services during the period listed above.
  2) Verification of Serious Mental Illness.
  3) Discharge address.
- This information will be used to verify your eligibility for the program and to send you a follow-up survey.
- You have the right to:
  1) Refuse the release of information.
  2) At any time contact the Crisis Housing Fund in writing and withdraw consent to the release of information.
  3) Request, in writing, a copy of any information collected about you.
  4) Request changes to the information if you feel it is inaccurate.

16) CLIENT SIGNATURE

I consent to the release of information from my client file at the applicant agency named above. (Please sign in BLUE ink)

Signature of Client:	**Date:**
Signature of Witness:	**Date:**

Payment will not be made without the client's ORIGINAL signature. You may contact the Crisis Housing Fund to withdraw consent at any time.

PLEASE MAIL COMPLETED FORM TO:
Minnesota Housing Partnership
Attn: Crisis Housing Fund
2446 University Avenue
Suite 140
Saint Paul MN 55114-1706

QUESTIONS?

Contact: Harlan Buckalew
651-649-1709
Harlan.Buckalew@mhponline.org