Region 1
Behavioral Health Authority
308-635-3173

HOUSING AND RENTAL TRANSITION PROGRAM (HART – SMI)

This document is to be used as an application for Housing Related Assistance under the State Rental Assistance Transition Voucher Program. This program is authorized under **Neb. Rev. Stat. 71-812(3)**. The program is designed to meet the intent of the Nebraska's Behavioral Health Reform (LB1083/2004, and LB40/2005).

Application contains drop down boxes and text entry boxes. A completed example is provided with instructions. Completed application will need scanned and emailed to Region I Housing and Supportive Living Coordinator.

The consumer eligibility criteria for the program:

1. An adult who has a serious mental illness; and
2. An adult who needs housing related assistance as documented by efforts to fully exhaust local options available in seeking rental assistance administered by local housing authorities and/or other entities; and
3. An adult who is
   a) **Priority One**:
      1) Extremely Low Income who is discharged from an inpatient mental health commitment, or
      2) Extremely Low Income who is eligible to move from a residential level of care to independent living to make room for a person being discharged from an inpatient mental health commitment;
   b) **Priority 2**: after the Region has demonstrated the Priority 1 groups are addressed, then the Region may start including consumers who are extremely low income at risk of an inpatient mental health commitment, at least in part because of lack of affordable independent housing.

Housing **a**nd **R**ental **T**ransition Program
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Main Phone: 308-635-3173 ext. 2187
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Application completed in its entirety for approval.

First Name_____**Middle Initial** _____**Last Name**_____**Suffix**_____

Date of Birth: _____**SSN:** _____

Street Address:

_____

City / STATE/ZIP

_____

County of Residence:_____**County of Admission:**_____

Phone number:_____

Type of Phone:

☐ No Phone ☐Landline ☐ Paid by minute cell phone ☐Unlimited cell phone ☐ Unknown

A goal for this program is for any eligible person with a serious mental illness or substance abuse diagnosis who wants to live independently to have the opportunity. This goal recognizes the need for supportive services to assist the consumer to improve his/her functioning so that he/she is successful and satisfied in the housing of choice. This is consistent with the recovery values of consumer self-determination and choice.

As a result, in order to be eligible for the state rental assistance program, the consumer must have an appropriate individualized service plan that:

(1) Person wants to live in a community setting _____

(2) Authorized behavioral health support services (such as Emergency Community Support, Community Support, Medication Management or other non-residential services consistent with consumer need).

(3) Person has a written treatment plan with a goal of independent living._____

(4) Does the person have an individualized service plan? ☐ Yes ☐ No

Whom will the consumer work with in the Community?

Caseworker:_____**Agency:** _____

Housing Priority:

Consumer must meet at least one of the following priorities.

Priority One

☐**Yes** ☐**No**	**1) Discharge from an inpatient mental health commitment**
☐**Yes** ☐**No**	Has this person been committed to psychiatric inpatient care?
☐**Yes** ☐**No**	Is the person ready for discharge from the hospital? NOTE: This means both Regional Centers and community hospitals receiving individuals under mental health commitment.
_____ MM/DD/YY	Expected Discharge Date _____
	COMMENTS:

☐**Yes** ☐**No**	**2) Move from residential level of care to independent living**
☐**Yes** ☐**No**	Is this person living at a Mental Health Residential Rehabilitation Level of Care?
☐**Yes** ☐**No**	Is the person ready to move into an Independent Apartment and receive "Mental Health Non-Residential" authorized services (such as Emergency Community Support, Community Support, Medication Management, or other services)?
_____ MM/DD/YY	Expected Discharge Date _____
☐**Yes** ☐**No**	Will this move result in a place for an eligible individual at the hospital level of care to use?
	COMMENTS:

Priority Two

☐**Yes** ☐**No**	**Consumer who is extremely low income <u>at risk of an inpatient mental health commitment</u>, at least in part because of lack of affordable independent housing.**
	Please check all that apply: ☐ A history of inpatient mental health board commitments within last five years ☐ Currently on an outpatient mental health board commitment ☐Subject to an emergency protective custody (EPC) within last five years ☐ Housing assistance will clearly prevent a psychiatric hospitalization ☐ Applicant is currently homeless ☐ Applicant has no income and appears eligible for SSI ☐ Applicant is living in independent housing that is not safe, decent, or affordable ☐ Housing assistance prevents applicant from moving into higher level of care

☐**Yes** ☐**No**	Is this person at risk and will this prevent them from moving to a higher level of care?

Section 8 Status:

The consumer needs to document the submission of an application for, and must have fully exhausted attempts to receive, local program rental assistance where his or her housing is located in order to be eligible for this program. Therefore, there needs to be documentation of the consumer's efforts to secure HUD Section 8 rental assistance vouchers that are available through local Public Housing Authority (PHA) or it needs to be documented that

- > The PHA does not have HUD Section 8 rental assistance vouchers;
- > The eligible consumer needs to be placed on a waiting list;
- > The consumer is not eligible for various reasons; or
- > Consumer needs for housing faster than Local PHA can process the application.

Check One

☐	1. Local PHA does not have HUD Section 8 rental assistance vouchers
☐	2. Consumer on Local PHA waiting list – Local PHA has HUD Section 8 rental assistance vouchers, the consumer is eligible, however, none are currently available Name of the local public housing authority:_____ Date consumer placed on the waiting list:_____
☐	3. Consumer not eligible – local public housing authority has HUD Section 8 rental assistance vouchers, however, the consumer is not eligible Name of the local public housing authority: _____ Date consumer declared ineligible: _____ Reason(s) the consumer is not eligible: _____
☐	4. Needs housing faster – The consumer needs housing more expeditiously than the Local PHA Section 8 application process as allows Name of the local public housing authority:_____ Date consumer can apply for Section 8:_____
☐	5. Other: **HOUSING FLEX FUNDS ONLY** – Has Section 8 voucher, homeless voucher, or other subsidized living arrangement; one-time housing flex funds will allow consumer to bridge to permanent housing or prevent eviction from subsidized living.

Number of Individuals in the Household: _____ **Preferred Language: _____**

SSI / SSDI Eligibility:

☐ Determined to be ineligible – N/A ☐ Eligible – Not Receiving Payments
☐ Eligible – Receiving payments ☐ Potentially Eligible

Medicaid Status:

☐ Determined to be ineligible – N/A ☐ Eligible – Not Receiving Benefits
☐ Eligible –Receiving Payments ☐ Potentially Eligible
☐ Retired ☐ Unknown

Insurance Status:

☐ Child Welfare ☐ HMA ☐ Medicaid

☐ Medicare ☐ No Insurance ☐ Private Self Pay
☐ Unknown

Primary Income Source:
☐ Disability ☐ Employment ☐ None
☐ Other ☐ Public Assistance

Priority Population:
☐ None ☐ MHB Discharged from LRC
☐ MHB Committed IP ☐ MHB Committed OP

Gender:
☐ Male ☐ Female
Pregnancy Status: ☐ No ☐ Yes
☐ Up to 6 weeks post-partum

Education Level:
☐ Unknown ☐ Grade 1 ☐ Grade 2
☐ Grade 3 ☐ Grade 4 ☐ Grade 5
☐ Grade 6 ☐ Grade 7 ☐ Grade 8
☐ Grade 9 ☐ Grade 10 ☐ Grade 11
☐ 12 years or GED ☐ 1st Year of College or University
☐ 2nd Year of College or Associate Degree ☐ 3rd Year of College or University 4th Year
☐ Bachelor's Degree ☐ Some Graduate Study – Degree not completed
☐ Master's Degree ☐ Doctorate Degree ☐ Vocational
☐ Self-Contained Special Education Class ☐ Technical Trade Class
☐ Special Education Class

Employment Status:
☐ Unknown ☐ Disabled
☐ Employed Full Time (35 hrs. +) ☐ Employed Part Time (< 35 hrs.)
☐ Homemaker ☐ Resident of Institute
☐ Retired ☐ Sheltered Workshop
☐ Supported Employment ☐ Unemployed – Laid off – looking
☐ Unemployed – Not seeking

Race:
☐ American Indian/Alaska Native ☐ Asian
☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander
☐ White ☐ Other

Ethnicity:
☐ Hispanic ☐ Non-Hispanic

Is a U.S. Citizen: ☐ Yes

Is a non-citizen with legal immigrant status ☐ (If this box is checked, contact Region I Systems Housing Coordinator to request a verification of immigration status)

Is a Veteran: ☐ Yes ☐ No

Legal Status:

☐ Unknown	☐ Civic Protective Custody (CPC)
☐ Court Order	☐ Emergency Protective Custody (EPC)
☐ Juvenile High Risk Offender	☐ MHB Commitment
☐ Parole	☐ Probation
☐ Voluntary	☐ Ward of the State

Number of Arrests in Past 30 Days: _____

Living Arrangements:

☐ Unknown	☐ Child Living with Parents/Relative
☐ Child Residential Treatment	☐ Crisis Resident Care
☐ Foster Home	☐ Homeless
☐ Homeless Shelter	☐ Jail / Correction Facility
☐ Other	☐ Other Institutional Setting
☐ Private Residence Receiving Support	☐ Private Residence with Housing Assistance
☐ Private Residence w/o Support	☐ Regional Center
☐ Residential Treatment	☐ Youth Living Independently

Marital Status:

☐ Unknown	☐ Cohabitating	☐ Divorced
☐ Married	☐ Never Married	☐ Separated
☐ Widowed		

Annual Taxable (gross) Household Income: $ _____

Applicant must provide proof of income at time of approval. Household sources of income would include employment income, Social Security and SSI pensions, disability, unemployment compensation, childcare, alimony, child support, scholarships and grants, and interest on checking or saving accounts.

Number of Dependents:

Has attempted suicide in past 30 days:

☐ Unknown ☐ Yes ☐ No

Poor Health in the last 30 days (Physical) ____ # of days
Poor Health in the last 30 days (Mental) ____ # of days

Any Suspected Trauma History. ☐ Yes ☐ No ☐ Unknown

IF "YES", please mark all that are applicable:

Type of Trauma	**As An Adult?**	As a Child?
Neglect	☐	☐
Physical Abuse	☐	☐
Sexual Assault / Rape	☐	☐
Victim / Witness to Community Violence	☐	☐
Victim of Crime	☐	☐
Ware / Political Violence / Torture	☐	☐
Natural Disasters	☐	☐
Emotional Abuse	☐	☐
Life Threatening Medical Issues	☐	☐
Physical Assault	☐	☐
Prostitution / Sex Trafficking	☐	☐
Sanctuary Trauma	☐	☐
Serious Accident / Injury	☐	☐
Sexual Abuse	☐	☐
Traumatic loss of a loved one	☐	☐
Victim of a Terrorist Act	☐	☐
Witness to Domestic Abuse	☐	☐

Neb. Rev. Stat. § 71-812 (3)(b)(i)

Adult with serious mental illness means a person eighteen years of age or older who has, or at any time during the immediately preceding twelve months has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and which has resulted in functional impairment that substantially interferes with or limits one or more major life functions. Serious mental illness does not include DSM V codes, substance abuse disorders, or developmental disabilities unless such conditions exist concurrently with a diagnosable serious mental illness.

Date of Diagnosis: _____

Does this Diagnosis meet the state Criteria for SED/SMI? ☐ Yes ☐ No

Diagnosis Clinician: _____

Diagnosis Codes –**PLEASE LIST THE CODE NUMBER**

A.

☐ First Treatment for diagnosis ☐ 12 months of longer duration

As a result of the entire diagnosis, please check all that apply:

☐ Causing "Physical Functioning" deficit ☐ Causing "Community Living Skills" deficit
☐ Causing "Vocational/Education" deficit ☐ Causing "Personal Care Skills" deficit
☐ Causing "Mood" deficit ☐ Causing "Interpersonal Relationships" deficit
☐ Causing "Psychological State" deficit ☐ Causing "Daily Living" deficit
☐ Causing "Social Skills" deficit ☐ Not Applicable

B. Click here to enter text.

☐ First Treatment for diagnosis ☐ 12 months of longer duration

As a result of the entire diagnosis, please check all that apply:

☐ Causing "Physical Functioning" deficit ☐ Causing "Community Living Skills" deficit
☐ Causing "Vocational/Education" deficit ☐ Causing "Personal Care Skills" deficit
☐ Causing "Mood" deficit ☐ Causing "Interpersonal Relationships" deficit
☐ Causing "Psychological State" deficit ☐ Causing "Daily Living" deficit
☐ Causing "Social Skills" deficit ☐ Not Applicable

C. Click here to enter text.

☐ First Treatment for diagnosis ☐ 12 months of longer duration

As a result of the entire diagnosis, please check all that apply:

☐ Causing "Physical Functioning" deficit ☐ Causing "Community Living Skills" deficit
☐ Causing "Vocational/Education" deficit ☐ Causing "Personal Care Skills" deficit
☐ Causing "Mood" deficit ☐ Causing "Interpersonal Relationships" deficit
☐ Causing "Psychological State" deficit ☐ Causing "Daily Living" deficit
☐ Causing "Social Skills" deficit ☐ Not Applicable

Additional BH Services

ACT – Assertive Community Treatment	CS (MH) Community Support MH	CS (SA) Community Support SA	DR – Day Rehabilitation	ECS (MH) Emergency Community Support MH	MM – Medication Management	SE – Supported Employment	OP – Outpatient Therapy	O – Other
☐	☐	☐	☐	☐	☐	☐	☐	☐

The information reported on this Application For Housing-Related Assistance under the Region I Housing and Rental Transition Program is true and correct to the best of my/our knowledge.

_____

Applicant's Signature Date

_____

Authorized Representative or Guardian Date

Behavioral Health Service Provider Certification: *Completed by ECS, CS, or other Caseworker*

As a behavioral health service provider, I hereby certify that the information provided above is true to the best of my knowledge and belief. I am providing this information for assisting the named Applicant in obtaining a determination for priority status in the Rental Assistance Program.

Signature of Behavioral Health Service Provider:_____ Date:_____

Printed Name:_____ Title:_____

Agency Affiliation:_____ Phone #:_____