**DHS/DMHAS Rental Subsidy Request Form**

**(Rev. 03/1/19)**

**Date submitted to DMHAS**: **Click here to enter text.**

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**Name of Consumer**: **Click here to enter text. Consumer SSN**: **Click here to enter text.**

**Consumer Personal Phone** xxx-xxx-xxxx (if none, type “none”): **Click here to enter text.**

Full Home Mailing Address of Consumer(If none, information will be mailed to the Community Agency Staff person in the section below. **Please do not enter a hospital address**):

**Click here to enter text.**

**Consumer personal email** (if none, type “none”): **Click here to enter text. Age:** **Click here to enter text.**

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**Community Agency Requesting:** **Click here to enter text.** **County**: **Click here to enter text.**

**Name of Staff**: **Click here to enter text. Phone Number/extension**: **Click here to enter text.**

**Staff mailing address: Click here to enter text. Staff email:** **Click here to enter text.**

**CSS Eligible (YES or NO): Click here to enter text.**

**BED ID: Click here to enter text. SITE ID: Click here to enter text.**

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**Name** of Licensed Clinician Providing Diagnosis: **Click here to enter text.**

**Mental Health Diagnosis**: **Click here to enter text.**

**Diagnosis of Substance Use Disorder**: **Click here to enter text.**

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**Does this Consumer have any children under age 18**? Yes\_\_\_ No\_\_\_   
 [**MUST** Provide Copy of Birth Certificates]

**Consumer has full residential custody of these children**: Yes\_\_\_ No\_\_\_

**Important:** This application will not be considered and will be returned to you if documented proof of full residential custody for each child is not provided at the time of submission. [Ex. School Records, Board of Social Services Documents, Doctor Notes, and/or Court Documents]

**Names, ages and genders of children:**

**Click here to enter text.**

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Please tell us where this Consumer is living this week (not their address) and describe the circumstances of their present living situation. **If the consumer is in the shelter or boarding home, please provide letter of confirmation from facility**.*(Ex. apartment or home (owned or rented), family or friend’s residence, shelter, street homeless, car, hospital, etc.)*

**Click here to enter text.**

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**If applicable, check ONE box below and provide name of hospital: Click here to enter text.**

State Hospital consumer - CEPP: State Hospital – Not CEPP:   
County Hospital: **Click here to enter text.** Other Hospital: **Click here to enter text.**

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**Is this Consumer ready to leave a DMHAS-funded Supervised Bed** (enter whether A+, A, B, or Family Care): **Click here to enter text.**

* If so, name of CEPP backfill (Request will not be considered and will be returned to you if not provided):

**Click here to enter text.**

Consumer is currently a Victim of Domestic Violence in their housing situation and needs to be removed for their own safety: If so, where are they now. **Please attach Police Reports**.

Explain: **Click here to enter text.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list locations and dates of any psychiatric hospitalizations this consumer has had in the past three years?

**Click here to enter text.**

Please list dates of any psychiatric ER/Screenings this consumer has had in the past three years?

**Click here to enter text.**

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**Is this Consumer eligible for Emergency Assistance/Temporary Rental Assistance through the local Board of Social Services**? Yes \_\_\_ No \_\_\_  
Please give a full accounting as to this Consumer’s application for such assistance through their local Board of Social Services(Please note, this application will not be processed if this question is left blank or notes, “n/a”):

**Click here to enter text.**

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Please briefly list any other relevant details or information regarding your subsidy request for this Consumer(in staff’s words):

**Click here to enter text.**