AngleZ
Behavioral Health Services

**For Agency Use Only**

| | |
|---|---|
| Date Received | |
| Application complete | |
| Application incomplete | |

**Office of Behavioral Health**
**Wrap-fund Application**
**Kennebec and Somerset**

***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: _____Fax:_____

---

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

Name:_____

Agency:_____

Phone Number:_____Email:_____

---



**841 Riverside Dr. Augusta Me 04330**
**www.anglezbhs.com**
**Phone / Fax 844-294-5306**

*Revised 8/1/2022*

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 Atrezzo®;

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 Atrezzo® 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 Atrezzo® attached to application.
**Continue to Section 2 – Financial.**

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



**841 Riverside Dr. Augusta Me 04330**
**www.anglezbhs.com**
**Phone / Fax 844-294-5306**

**Section 17 Eligibility Form to be completed only for applicants that are <u>not already</u> 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: | |

**<u>Specific Eligibility Requirements</u>**.

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

A. 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:

a) 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 seventy-two (72) hours, or residential treatment unless community support program services are provided; based on documented or



**841 Riverside Dr. Augusta Me 04330**
**www.anglezbhs.com**
**Phone / Fax 844-294-5306**

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 twenty-four (24) months, for a non-excluded DSM 5 diagnosis; or

c) Has been discharged from a mental health residential facility, within the past twenty-four (24) months, for a non-excluded DSM 5 diagnosis; or

d) Has had two 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, for a non-excluded DSM 5 diagnosis; or

e) Has been committed by a civil court for psychiatric treatment as an adult; or

f) 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

g) 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.

C. 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.

D. 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 twelve (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 seventy-two (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 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,LHEAP 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: _____)

☐ 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 ☐



**841 Riverside Dr. Augusta Me 04330**
**www.anglezbhs.com**
**Phone / Fax 844-294-5306**

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 Bureau of Veteran Services 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 Bureau of Veteran Services The On line request form can be access at https://www.maine.gov/veterans/docs/MBVS-Request-Form-Online-Fillable.pdf or Field office locations https://www.maine.gov/veterans/veterans-services-offices/locations/index.html |

What are your current household monthly expenses?

| **Category** | **Household Expenses** | **Category** | **Household Expenses** |
|---|---|---|---|
| Total Cost of 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** (i.e. General Assistance, Section 8 housing, LHEAP, Salvation Army, Religious Organizations etc.).

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

| Organization/Agency Date of 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 $600.00 any amount over will make up the total allowance for the applicant for state fiscal year of July 1, 2021–June 30, 2022.
Applicant cannot apply for Wrap -funds until the start of the next state fiscal year, July 1, 2022.
** Funds may be used for more than one (1) need below but cannot exceed $600.00 per State fiscal year per Applicant for Non-Housing Assistance.

_____***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 no, 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:**

a. Wrap can fund applicant/ tenant portion of their rent equal to or less than one month's FMR value.

b. These funds can pay for applicant/tenant portion of back rent owed equal to or less than one (1) month's total rent FMR value. This will allow for applicants back rent to be funded by Wrap equal to or less than FMR but would not be restricted to one month's rent.

c. 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.

d. 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.



**841 Riverside Dr. Augusta Me 04330**
**www.anglezbhs.com**
**Phone / Fax 844-294-5306**

Please provide amount of rent paid by applicant $_____ and amount of rent paid by subsidy program $_____

If no, what are the sources of income to pay rent: _____

_____ # of bedrooms _____ City/town of housing

_____**Temporary Housing in a motel**

Criteria 1-7 must be verified by Applicant and case manager.

1) Applicant is homeless and Applicant has been denied access to homeless shelter.
2) Case Manager shall outreach homeless shelters and domestic violence shelters (if applicable) within the State. List all shelters outreached including date of outreach.
3) Applicant has behavioral and/or physical health issues which prohibits staying at a homeless shelter.
4) Applicant/Provider must provide two (2) hotel rates from area motels.
5) Temporary housing may not exceed fourteen (14) days s calendar days unless approved by the Department.
6) Applicant must demonstrate they have, or are in the process of applying for State, Federal, local housing subsidies, General Assistance, r Bridging Rental Assistance Program (BRAP), Shelter Plus Care to show efforts are being made to obtain permanent, safe and stable housing.
7) Applicant is required to have an assigned case manager
8) The case manager must attest there are adequate services in place to support the individual, including a safety plan to mitigate personal and property risks.
9) Motel Requires Deposit

***Temporary Housing- extensions in a motel**

1) Extensions shall be determined by the Department. Extensions are granted in seven (7) calendar day intervals. An extension will not be granted on more than two (2) occasions. Prior to requesting an extension from the Department, the following shall be completed and submitted to the OBH Program Manager:
    i. Documentation that all-natural supports (relatives, friends, etc.) were explored; and
    ii. Documentation of outreach to Homeless shelters and Domestic Violence shelters if applicable.

_____* **Prescribed Medications –** Not to exceed $250.00

6. Only provide Wrap Funds for "Prescribed Medications" (all narcotics listed on the DEA website are excluded) (as outlined in F-1 Proforma) to eligible Applicants that have additionally provided the following with their Wrap Funds application:

a. A copy of the prescription signed by the prescriber, with Applicant's name;
b. The pharmacy bill for the "Prescribed Medications"; and
c. Vendor Tax ID Number.

_____* _____*** Electric bill –** Not to exceed $700.00

7. Only provide Wrap Funds for an "Electric bill to maintain power in the Applicant's residence, in the case of an emergency" (as outlined in F-1 Proforma),. prior electric bills may be considered as long as it does not exceed one year from date of application,

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;

1) The Applicant must provide a copy of an approved payment plan from power vendor for remaining amount and attach to the Wrap -fund application.
2) The Applicant must provide a copy of the prior electric bill ( no more than one year old ) 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.

3) 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 – Not to exceed $ 500.00__ (one hundred (100) gallons of heating oil or Kerosene or one hundred (100) pounds lbs. of propane, one (1) ton of pellets (for pellet stove), or one (1) cord of wood)

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 $500.00 (Please attach eye glass prescription, estimate and/or bill for eye glasses/ vision exam in applicant's name from the provider)

a. Vendor Tax ID Number.

_____*__Oral/Dental Care__-not to exceed $600.00 (Please attach Oral/Dental Care estimate and/or bill in applicant's name from the provider)

a. Vendor Tax ID Number.

c. If Oral/Dental Care costs are over $600.00 please refer applicant to Community Dental Services ; an OBH/OCFS granted funded program for no cost dental services

_____ ***Denture Care** -not to exceed $1000.00 Please attach prescription for dentures by M.D in the applicant's name, medical reason, estimate and/or bill in applicant's name for dentures from the provider.)

a. Vendor Tax ID Number.

If denture costs are over $500.00 please refer applicant to Community Dental Services ;Services; an OBH/OCFS granted funded program for no cost dental services

_____ *__Transportation to include car repairs and transportation to access mainstream services__-not to exceed $500.00 (Please attach estimate of repair cost).

Please attach car repair estimate from certified car mechanic. Car repairs can be completed by consumer 's choice of vendors.

b. 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)

Provide documentation that MaineCare will not cover cost of transportation to Mainstream Resources .

_____ *__Other Emergency Need__ -not to exceed $500.00 (Please attach estimate)

Please describe "Other Emergency Need":

_____

_____

_____ *__Emergency Need as referred by the Department__

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

**Please note that Wrap Funding will not pay for: telephone or cell phone payments, purchasing entertainment electronics (to include: laptops, televisions, cell phones , electronic tablets, etc.) vehicle payments, vehicle insurance, vehicle registration, cable/streaming/internet service bills; mental health treatment or services, substance use disorder treatment or services, evaluations or assessments, any legal services/representation/lawyer fees, additional funding stream for contracting agencies, pet related expenses; Court ordered DEEP or offender treatment; 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 household/immediate family member's bills and utility bills over a one year old.**

**Section 4- Applicant and Committee Checklist**

For each application, the **Wrap -funds 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 or No |
| Do Wrap -funds create a resolution to this emergency need? | Yes or No |
| Has the applicant verified that they have applied for all federal, state and community subsidies? | Yes or No |
| Does the applicant's current household budget and income plan reflect that they are living with in their financial means? | Yes or No |
| Does the Wrap -funds request fall under the Wrap -fund emergency need and allowable amount? | Yes or No |

**Note**: All approved applications requests for Wrap funds must fall under the following Wrap und needs and Wrap -fund Allowable Amounts as described in Table A.
Wrap funds can be used within the State fiscal year of July 1, 2022 –June 30, 2023.



**841 Riverside Dr. Augusta Me 04330**
**www.anglezbhs.com**
**Phone / Fax 844-294-5306**

AngleZ
Behavioral Health Services

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: | $ |
| ABHS PORTION OF SECURITY DEPOSIT: | $ |

In consideration of the Landlord's leasing residential premises to Tenant as above indicated and the landlord's following agreements concerning the security deposit, ABHS is willing to pay the indicated ABHS portion of the security deposit. Landlord therefore agrees as follows:

The ABHS 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 ABHS 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 ABHS in writing of any termination of the lease or of Tenant's habitation of the leased premises and shall return the ABHS portion of the security deposit to ABHS 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 ABHS a written itemization of all amounts charged against the security deposit together with payment of any



**841 Riverside Dr. Augusta Me 04330**
**www.anglezbhs.com**
**Phone / Fax 844-294-5306**

remaining balance of the ABHS portion of the security deposit after application of the itemized retentions. In no event shall ABHS be liable for any damages, costs or claims of any kind under the lease either in excess of the ABHS 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: |
| Date: |
| Printed Name: |
| Title: |

*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: |

Please return completed applications and documents by any of the following:

Fax: 844-294-5306

US Mail: 841 Riverside Drive Augusta Me 04330

Email: wrap@anglezbhs.com



**841 Riverside Dr. Augusta Me 04330**
**www.anglezbhs.com**
**Phone / Fax 844-294-5306**