

FY '19
WRAP FUND
APPLICATION
PACKET

(REVISED 7/26/18)

COMMUNITY HEALTH AND COUNSELING SERVICES
42 CEDAR STREET
BANGOR, ME 04401

**Wrap Fund Application
Cover Page**

Wrap funds help meet the **emergency** needs of adult individuals with **Severe and Persistent Mental Illness (SPMI)** that cannot be otherwise met through regular systems of care. **This is a fund of last resort. Applicants must demonstrate they have exhausted all other resources.** There is an application process and criteria for how funds are to be used.

Community Health and Counseling Services administers the Wrap Fund for Hancock, Penobscot, Piscataquis or Washington Counties. If you live in any of these counties, have an emergency need, and **meet the eligibility guidelines for Section 17 services**, please complete the attached application.

We strongly encourage working with your case manager or other provider to complete the application. **CHCS is not responsible for helping you complete the application.** All incomplete applications will be returned.

Completed applications may be returned to:

By mail: Community Health and Counseling Services
 ATTN: Wrap Fund
 42 Cedar Street
 Bangor, ME 04401

By FAX: (207) 942-9290 (NEW FAX NUMBER 6/19/18!!!)

You may also drop off your application to any of the following CHCS offices:

BANGOR – 42 Cedar Street
DOVER-FOXCROFT – 1093 W. Main Street
ELLSWORTH – 52 Christian Ridge Road
LINCOLN – 313 Enfield Road
MACHIAS – 15 Kids Korner

For questions related to the Wrap Fund, please contact:

Tracy Goodridge
CHCS
42 Cedar Street
Bangor, ME 04401
(207) 922-4704
(800) 924-0366, ext. 4704
tgoodridge@chcs-me.org

Applications are also available on the Home page of our website at www.chcs-me.org.

Applications will be reviewed and returned to applicant if incomplete. Applicants or the requesting case manager will be sent a letter of approval or denial within five (5) business days of receipt of a complete application.

Any applicant who disagrees with the decision may appeal the denial within ten (10) business days of receipt of the decision in writing to: SAMHS Quality Management Specialist, 41 Anthony Avenue, SHS #11, Augusta, ME 04333-0011.

WRAP FUND APPLICATION

- If applicant **RECEIVES** Section 17 services, proof of enrollment and authorization by KEPRO *Atrezzo* must be attached;
- If applicant **DOES NOT RECEIVE** Section 17 services, the Section 17 eligibility form must be completed and signed by a licensed professional, **IF** the applicant meets the eligibility criteria on the form.
- Applicants must list other resources/agencies that have been sought to meet the requested need – at least 3 are recommended.

Each Wrap Fund Category has specific requirements. Please review them and be sure to provide required information.

WRAP will pay no more than Fair Market Rent Rates as determined by HUD.

2018 Fair Market Rent Rates (HUD)					
County	Efficiency	One Bedroom	Two Bedroom	Three Bedroom	Four Bedroom
Bangor HUD Metro Area*	\$666	\$740	\$938	\$1,176	\$1,589
Hancock	\$696	\$798	\$974	\$1,267	\$1,377
Penobscot**	\$630	\$634	\$825	\$1,034	\$1,124
Piscataquis	\$559	\$607	\$697	\$1,014	\$1,125
Washington	\$617	\$621	\$764	\$965	\$1,102

**(Bangor, Brewer, Eddington, Glenburn, Hampden, Hermon, Holden, Kenduskeag, Milford, Old Town, Orono, Orrington, Penobscot Indian Island Reservation, Veazie)*

Requests for assistance will be approved if:

- The request is for an emergency need and that all other resources have been exhausted.
- The Applicant has demonstrated that Wrap-funds will create a resolution to this urgent need.
- The Applicant has demonstrated that they have applied for all Federal, State and local subsidies.
- The Applicant’s current financial status reflects that they are living within their financial means; and
- The Wrap-funds request falls under both the Wrap-fund “Wrap-fund Needs” and “Wrap-funds Allowable Amounts” (as described in Table A).

Table A	
<u>Wrap-fund Needs: Housing Assistance</u>	<u>Wrap-funds Allowable Amounts (per State fiscal year, per Applicant)</u>
Rent	Cannot exceed one (1) month’s FMR
Security Deposit	Cannot exceed one (1) month’s FMR
Temporary Housing in a motel	Not to exceed median hotel rate from two (2) motels in the area. Not to exceed two (2) weeks’ stay, unless approved by the Department in writing.
<u>Wrap-fund Needs: Non-Housing Assistance</u>	<u>Wrap-funds Allowable Amounts (per State fiscal year, per Applicant)</u>
Prescribed Medications; up to two (2) weeks supply (excluding narcotics)	Not to exceed \$250.00
Electric bill to maintain power in the Applicant’s residence or prior electric bill if this allows the applicant to move to permanent, stable and safe housing.	Not to exceed \$500.00

Emergency Fuel	Not to exceed \$500.00
Vision/Eye Care	Not to exceed \$250.00
Oral/Dental Care	Not to exceed \$250.00
Dentures if prescribed by a MD for medical reasons	Not to exceed \$500.00
Transportation to include car repairs and transportation to access Mainstream Services	Not to exceed \$250.00
Other emergency needs (must describe)	Not to exceed \$250.00
Emergency Need, as referred by the Department	Department discretion

**Adult Mental Health
Wrap-fund Application
Hancock, Penobscot, Piscataquis,
and Washington Counties**

For Agency Use Only

Date Received	
Application complete	
Application incomplete	

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 Care Connection 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:

- 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 DSM4 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 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
 - c) Has been discharged from a mental health residential facility, within the past 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 72 hours per episode, within the past 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 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 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 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, LHEAP, etc.)	\$	\$	\$	\$
Employment	\$	\$	\$	\$
Rent paid by Housing Subsidy (BRAP, Shelter + 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

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 <input type="checkbox"/> No <input type="checkbox"/>
2a	If no, would you like help from the Maine Veterans' Service to apply for VA benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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?

Category	Household Expenses	Category	Household Expenses
Amount 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 (i.e. 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

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.

*If the Security Deposit, Rent Assist or Temporary Housing in a Motel exceeds \$500, 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.

_____ ***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 and stable housing.

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

If no subsidy, 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 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 State, Federal, local housing subsidies, General Assistance, and/or Bridging Rental Assistance Program (BRAP) to show efforts are being made to obtain permanent and stable housing.

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

If no subsidy, 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 and stable housing.

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

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

***Electric bill** to maintain power in Applicant's residence or prior electric bill if this allows the Applicant to move to 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 in 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)

- 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 (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.)

***Transportation to include car repairs and transportation to access mainstream services**-not to exceed \$250.00 (Please attach estimate of repair cost).

- a. 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.
- c. 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 \$ _____

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 within 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 -fund needs and Wrap -fund Allowable Amounts as described in Table A. Wrap -funds can be used for housing or emergency needs, 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.

**Community Health and Counseling 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:	\$
CHCS 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, Community Health and Counseling Services (CHCS) is willing to pay the indicated CHCS portion of the security deposit. Landlord therefore agrees as follows:

The CHCS 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 CHCS 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 CHCS in writing of any termination of the lease or of Tenant's habitation of the leased premises and shall return the CHCS portion of the security deposit to CHCS 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 CHCS a written itemization of all amounts charged against the security deposit together with payment of any remaining balance of the CHCS portion of the security deposit after application of the itemized retentions. In no event shall CHCS be liable for any damages, costs or claims of any kind under the lease either in excess of the CHCS 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.



Community Health and Counseling Services

P.O. Box 425, Bangor, Maine 04402-0425

(207) 947-0366

Dear Vendor:

Thank you for doing business with the Agency. In order to keep our records up to date please complete a W-9 Form.

When completing the W-9, please use your name as it appears on your federal income tax return. If you conduct business under a different name or company name, please enter that on line 2.

Select the correct classification for your business. If you are an individual or self-employed business, you would choose "Individual/Sole Proprietor" while other types of businesses should choose which type of business they are operating under – "C Corporation", "S Corporation", "Partnership" or "Trust/estate". (Typically this would follow what type of federal income tax return you file.)

Complete the address section by listing your full mailing address along with your city, state and ZIP code.

Fill in the appropriate identification number as it appears on your federal income tax return. For an individual/self-employed business, this would be your Social Security Number. For other types of businesses, this would be your Employer Identification Number (EIN) that you have received from the Internal Revenue Service. (Again this number can be found on your federal income tax return).

Sign and date the form. You should keep a copy for your files and return the original to us. If it would be easier for you to fax it, our fax number is (207) 945-5785.

If you have any questions/concerns, please feel free to contact me at (207) 922-4854 or bgodin@chcs-me.org.

Sincerely,

Brenda Godin, Controller

Enclosure



P.O. Box 425, Bangor, Maine 04402-0425

(207) 947-0366

COMMUNITY HEALTH AND COUNSELING SERVICES
Substitute W-9 Form

PURPOSE: This form replaces IRS W-9 form per the IRS W-9 language: "If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9."

Complete this form if you: 1) receive payment from Community Health and Counseling Services, and/or 2) are a vendor who provides services or goods to Community Health and Counseling Services.

ALL items with an asterisk (*) must be completed.

TAXPAYER ID NUMBER * (TIN) (Provide **ONE** only)

Social Security Number (SSN) _____ - _____ - _____

OR

Employer ID

Number (EIN) _____ - _____

Organization Type * choose **ONE**

_____ Individual

OR

_____ Company

Classification * choose **ONE**

_____ Individual/sole proprietor

_____ Corporation

_____ Partnership

_____ Trust/estate

_____ Other explain _____

Legal Name * (Must provide: Legal name as shown on federal income tax forms and tied to the ID number, SSN=first & last name/EIN=business name)

Legal Name _____

Alias/DBA _____

Mailing Address *

Address _____

Address _____

City/State/ZIP _____

Under penalties of perjury, I certify that: 1) the number shown on this form is my correct taxpayer identification number, and 2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3) I am a U.S. citizen or other U.S. person (defined by the IRS). Ref: www.irs.gov.

Authorized Signature, Title & Date *

Return Form to: Community Health and Counseling Services, Attn: Finance Dept., P.O.Box 425, Bangor, ME 04402-0425 (Fax 207-945-5785)