

**FY '22**

**WRAP FUND**

**APPLICATION**

**PACKET**

**(REVISED 7/28/2021)**

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

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, and 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) 922-4600, ext. 6487 (NEW PHONE NUMBER!)

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) 922-4600, ext. 6487  
tgoodridge@chcs-me.org

Applications are also available on the Home page of our website at [www.chcs-me.org](http://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.

**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: \_\_\_\_\_

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Please complete, if applicable:

Applicant's Provider Agency: \_\_\_\_\_

Case Manager Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

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

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

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I certify and attest that the attached information is true and complete to the best of my knowledge and belief.

***Name of Applicant/Consumer who 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:

**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 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 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 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.

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**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.)

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**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.) Please circle.	\$	\$	\$	\$
Employment	\$	\$	\$	\$
Rent paid by Housing Subsidy (BRAP, Shelter Plus Care, Section 8 etc.)				
Child Support	\$	\$	\$	\$
Alimony Received	\$	\$	\$	\$
Worker's Compensation	\$	\$	\$	\$
Other Income:	\$	\$	\$	\$
<b>TOTAL</b>	\$	\$	\$	\$

**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". The online request form can be accessed at <a href="http://www.maine.gov/veterans/docs/MBVS-Request-Form-Online-Fillable.pdf">www.maine.gov/veterans/docs/MBVS-Request-Form-Online-Fillable.pdf</a> or Field office locations <a href="http://www.maine.gov/veterans/veterans-services-offices/locations/index.html">www.maine.gov/veterans/veterans-services-offices/locations/index.html</a>		



**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): (Such as laundry, personal care, co-pays, medications, food over SNAP, pet care, etc)	
Alimony Paid			
Child Support Paid			
*Transportation Expense			
**Heating Expense			
**Electric Expense			
**Water & Sewer			
Telephone/ Cell Phone /Internet/ Cable (circle)			
<b>Total</b>		<b>Total</b>	

**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 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.

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**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 \$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 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 (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.

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

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**\*\*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. These must be verified by a clinician.
- 4) Applicant/Provider must provide two (2) hotel rates from area motels.
- 5) Temporary housing may not exceed two (2) weeks 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, Bridging Rental Assistance Program (BRAP), Shelter Plus Care to show efforts are being made to obtain permanent, safe and stable housing.
- 7) Applicant has a case manager and a documented Individual Support Plan (ISP) identifying steps and goals to obtain permanent housing shall be completed.
- 8) Case manager must attest there are adequate services in place to support the individual, including a safety plan to mitigate personal and property risks.

**\*Temporary Housing in a motel extension:**

- 1) Extensions shall be determined by the Department. Extensions are granted in seven (7) 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.

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

- 1) Applicant must attach copy of the prescription, signed by the prescriber, with Applicant's name,
- 2) Applicant must attach a pharmacy bill to the Wrap -fund application.
- 3) **\*\*All narcotics listed on DEA website are excluded**

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**\* Electric bill** to maintain power in the Applicant's residence, in the case of an emergency. 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.
- 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 into a 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.

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**\*Emergency fuel** (one hundred (100) gallons, or one hundred (100) pounds lbs. of propane, one (1) ton of pellets (for pellet stove), or one (1) cord of wood); not to exceed \$500

- 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.

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**\*Vision /Eye Care**-not to exceed \$300.00 (Please attach eye glass prescription, estimate and/or bill for eyeglasses 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) If Oral/Dental Care costs are over \$250.00, please refer applicant to Community Dental Services, an OBH/OCFS grant funded program for no cost dental services.

\_\_\_\_\_ **\*Denture Care** -not to exceed \$500.00 (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.) If Denture Care costs are over \$500.00, please refer applicant to Community Dental Services, an OBH/OCFS grant funded program for no cost dental services.

\_\_\_\_\_ **\*Transportation to include car repairs and transportation to access mainstream services**-not to exceed \$300.00 (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/Logisticare will not cover cost of transportation to Mainstream Resource.
- d. Verification of current vehicle insurance and inspection, or verification that repairs will allow vehicle to pass inspection.
- e. Provide a copy of Kelley Blue Book value to document that cost of repairs does not exceed 60% of value.

\_\_\_\_\_ **\*Other Emergency Need** -not to exceed \$300.00 (Please attach estimate)  
Please describe "Other Emergency Need":

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\_\_\_\_\_ **\*Emergency Need as referred by the Department**

**Wrap -fund amount requested by Applicant \$** \_\_\_\_\_

## **2021 Fair Market Rent Rates (HUD)**

<b>County</b>	<b>Efficiency</b>	<b>One Bedroom</b>	<b>Two Bedroom</b>	<b>Three Bedroom</b>	<b>Four Bedroom</b>
Bangor HUD Metro Area*	\$708	\$826	\$1,057	\$1,315	\$1,729
Hancock	\$746	\$782	\$920	\$1,175	\$1,248
Penobscot**	\$595	\$658	\$867	\$1,078	\$1,176
Piscataquis	\$484	\$618	\$734	\$1,011	\$1,271
Washington	\$599	\$603	\$795	\$989	\$1,085

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

*\*\*All other Penobscot County communities not listed in Bangor HUD Metro Area*

#### 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 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, 2021 –June 30, 2022.

**Wrap Funding will not pay for:** telephone or cell phone payments, purchasing entertainment electronics (to include: laptops, television, cell phones, tablets, etc. ), vehicle payments, vehicle insurance, vehicle registration, cable/streaming/internet service bills; mental health treatment or services, substance use disorder treatment or services, evaluation or assessments, any legal services/representation/lawyer fees, additional funding stream for contracting agencies, pet related expenses, Court ordered DEEP or offender treatment; purchasing entertainment electronics (to include: laptops, televisions, iPhone, iPads, etc.); 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 one year old.

**Community Health and Counseling Services  
SECURITY DEPOSIT AGREEMENT**

For Security Deposits only: Must be signed by new Landlord

<b>Landlord</b>	<b>Tenant</b>
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.



**VENDOR (not applicant) INFORMATION FOR ALL REQUESTS THAT ARE NOT SECURITY DEPOSITS**

Check Payable To:

Mailing Address:

Phone Number:

Federal Tax ID# or Social Security Number:



Community Health and Counseling Services

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

(207) 947-0366

(207) 990-4730 TDD for Hearing Impaired

Website [www.chcs-me.org](http://www.chcs-me.org)

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](mailto:bgodin@chcs-me.org).

Sincerely,

Brenda Godin, Controller

Enclosure



COMMUNITY HEALTH AND COUNSELING SERVICES  
P.O. Box 425, Bangor, Maine 04402-0425  
(207) 947-0366

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: Wrap Fund., P.O.Box 425, Bangor, ME 04402-0425 (Fax 207-942-9290)