Rice County HRA Bridges Pre Application

This application is for the Bridges Program only. Read the instructions for each section and answer all required questions. Incomplete applications will slow processing and may be returned. **Once completed, please give this form to Rice County Housing Authority**. Do **not** send it to Minnesota Housing.

Housing Choice Voucher Requirement

To receive Bridges rental assistance, you must also apply for a Section 8 Housing Choice Voucher. If the waiting list is currently closed, you must apply as soon as the waiting list opens and provide evidence of your application. Failure to do so will result in termination from the Bridges program, and you will no longer receive a rent subsidy.

Have you applied for a Section 8 Housing Choice Voucher?

☐ YES – Complete the application information below.

Housing Authority Name	Date of Application

☐ NO – The waiting list is closed. The anticipated date the waiting list will open is_____. Do you understand that you must apply as soon as the waiting list opens, even if you have a Bridges voucher? ☐ YES ☐ NO

Personal Information

Name:			
Address (if applicable):			
City:	State:	Zip:	County:
Home Phone:	Work Phone:		
Email (optional):			

Extent of homelessness prior to program intake:

☐ Not homeless ☐ 1st time homeless ☐ 2nd or 3rd time homeless

☐ Long-term homeless (homeless for 12 or more consecutive months or four times in the last three years)

Living situation prior to program intake:

☐ Emergency shelter
☐ Transitional housing
☐ Permanent supportive housing
☐ Psychiatric facility or hospital
☐ Hospital (non-psychiatric)
☐ Substance abuse treatment or detox
☐ Jail, prison, other correctional facility
☐ Board and Lodge
☐ Hotel/motel without voucher
☐ Living with family
☐ Living with friends
☐ Rental house/apartment
☐ Nursing home
☐ Group home or foster care
☐ Place not meant for habitation
☐ Don't know
☐ Refused
☐ Other:

Emergency Contact	
Name:	
Address:	
Phone:	Relationship:
Case Manager (if applicable)	
Agency:	
Name:	Phone:
Email:	
Address:	
Crisis Assistance Organization	
Agency:	Phone:

Household Information

Family Status (check all that apply):

☐ Head of household or spouse is 62 or older
☐ Head of household or spouse is handicapped or disabled
☐ Another family member is handicapped or disabled
☐ None of the above

Marital Status:

☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

List the head of household and all other individual(s) who will be residing in the unit. Include the relationship of each family member to the head of household.

Full Name	Relationship	Birth Date	Age	Sex	Social Security Number
	HEAD				

You are not required to provide race and ethnicity information, but supplying it will help with monitoring and determining compliance with civil rights laws.

Race of Head of Household

☐ Asian
☐ Black/African American
☐ Native American/Alaskan Native
☐ Native Hawaiian/Pacific Islander
☐ White

Ethnicity of Head of Household

☐ Hispanic
☐ Non-Hispanic

Language of preference: ☐ English ☐ Somali ☐ Other-please specify_____

Income Information

Include income for all household members age 18 and over. Income eligibility will be recertified annually. **You are responsible for immediately notifying your local Housing Agency, *in writing*, if your income changes at any time while receiving assistance.**

YES	NO	
☐	☐	1. Do you work full-time, part-time or seasonally?
☐	☐	2. Do you expect to work for any period during the next year?
☐	☐	3. Do you work for cash?
☐	☐	4. Do you expect a leave of absence from work due to lay-off, medical, maternity or military leave?
☐	☐	5. Do you receive or expect to receive unemployment benefits?
☐	☐	6. Do you receive or expect to receive child support?
☐	☐	7. Are you entitled to child support that you are not receiving?
☐	☐	8. Do you receive or expect to receive alimony?
☐	☐	9. Are you entitled to alimony that you are not receiving?
☐	☐	10. Do you receive or expect to receive public assistance (TANF, MFIP, GA, FGA)?
☐	☐	11. Do you receive or expect to receive Social Security benefits (SSI, MSA, SSDI, RSDI)?
☐	☐	12. Do you receive or expect to receive income from a pension or annuity?
☐	☐	13. Do you receive or expect to receive regular contributions from organizations or from individuals not living with you?
☐	☐	14. Do you receive income from assets, including interest on checking or savings accounts, interest and dividends from certificates of deposit, income or interest from stocks or bonds, or income from rental property?
☐	☐	15. Do you own real estate or any asset for which you receive no income (checking account, cash)?
☐	☐	16. Have you sold or given away real property or other assets (including cash) for less than their fair market value during the past two years? If yes, when Amount Type of Asset

For each YES above, provide income details below. Add additional pages, if necessary, as well as the name and address of employers. Be sure to list gross income (pre-tax income) for wages, Social Security and Medicare.

# (1-16 above)	Explanation of Income	Monthly Income Amount
	Total	

Employment	
Name and address of current employer, if applicable:	Length of employment:
Supervisor's name:	Supervisor's phone number:
Name and address of current employer, if applicable:	Length of employment:
Supervisor's name:	Supervisor's phone number:

Assets

All assets must be listed below.

Bank or Agency Name	Type of Account	Account Number	Balance

You may be required to provide evidence of income and assets including:

- Benefit award letters from Social Security, MSA, GA, etc.
- Payroll check stubs showing hours worked and rate of pay (provide, at a minimum, one month)
- Copy of a recent bank statement showing the account balance and interest rate
- Any other documentation of income and assets that may be available

Applicant Certification

The application must be filled out completely and signed by the applicant ***and all other adults 18 or older*** living in the household.

With my signature below, I verify that:

- I have provided true and correct information on this application, to the best of my knowledge and belief.
- I have read and understand the information contained on the Government Data Practices Act Statement and Authorization to Obtain Information, and acknowledge so by signing said form (attached).
- Assistance through the Bridges Program is temporary and will continue only until Section 8 assistance or another permanent subsidy is obtained.

_____

Head of Household's Signature Date

_____

18+ Household Member's Signature Date

_____

18+ Household Member's Signature Date

_____

18+ Household Member's Signature Date

_____

18+ Household Member's Signature Date

Authorization for Release of Information

Rice County Housing and Redevelopment Authority
320 3rd Street N.W. ~ Faribault, MN 55021

CONSENT: I authorize and direct any Federal, State, or Local agency, organization, business, or individual to release to the Rice County Housing and Redevelopment Authority any information or materials needed to complete and verify my application for participation, and/or to maintain my continued assistance under the Section 8 Housing Choice Voucher program and/or other housing assistance programs. I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) in administering and enforcing program rules and polices.

INFORMATION COVERED: I understand that, depending on program policies and requirements, previous or current information regarding me or my household may be needed. Verifications and inquiries that may be requested, included but are not limited to:

Identity of Marital Status	Employment, Income and Assets	Residences and Rental Activity
Medical or Child Care Allowances	Credit and Criminal Activity	

I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for and continued participation in a housing assistance program.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED: The groups or individuals that may be asked to release the above information (depending on program requirements) include, but are not limited to:

Previous Landlords/Housing Agencies	Past and Present Employers	Veterans Administration
Courts and Post Offices	Welfare Agencies	Retirement Systems
Schools and Colleges	State Unemployment Agencies	Banks an other Financial Institutions
Law Enforcement Agencies	Social Security Administration	Credit providers and Credit Bureaus
Support and Alimony Providers	Medical and Child Care Providers	Utility Companies

COMPUTER MATCHING NOTICE AND CONSENT: I understand and agree that HUD or the Public Housing Authority my conduct computer matching programs to verify the information supplied for my application or recertification. If a computer match is done, I understand that I have a right to notification of any adverse information found and a chance to disprove that information. HUD may in the course of its duties exchange such automated information with other Federal, State or Local agencies, including but not limited to: State Employment Security Agencies; Department of Defense; Office of Personnel Management; the U.S. Postal Service; the Social Security Administration; and State welfare and food stamp agencies.

CONDITIONS: I agree that a photocopy of this authorization may be used for the purposes stated above. This authorization will stay in effect one year from the date signed.

SIGNATURE	PRINTED NAME	DATE
Head of Household:		
Co-Head:		
Additional Adult:		
Additional Adult:		
Additional Adult:		

Rice County HRA Long-Term Homelessness Eligibility Form

This form is required to verify eligibility for Long-Term Homelessness (LTH) and must be kept in the tenant file of the housing provider.

Verification Steps

The service provider/assessor who completes this form should:

- List **two** to **four** years of all housing history below, starting with the most recent date. Approximate dates (month/year) may be used, and intermittent shelter stays (e.g., within one month) may be grouped together. If necessary, continue to list living situations on page three.
- For **type of living situation**, choose from: emergency shelter, transitional housing, psychiatric facility, substance abuse treatment, hospital, jail/prison, staying with friends/family, rental housing, a place not meant for human habitation, or other (specify).
- The agency documenting LTH eligibility must attempt to verify each homeless episode and attach a paper copy of the evidence to this form. **Verification** may be via: letter, Third Party Verification Form, email, phone conversation (include date, name and number of the person you talked to), or evidence in HMIS or another database.
    - If third party verification is not feasible for one or more of the homeless episodes, the applicant may self-certify. List "self-cert" in the verification type, and explain in the comments section why third party verification is not possible.

Print Applicant Name _____

Start/End Dates	Type of Living Situation	City and State AND Facility Name OR Address	Reason for Leaving	Verification Type	# Months Homeless

Comments/Notes/Reason For Self-Certification

Households Experiencing Long-Term Homelessness: Persons, including individuals, unaccompanied youth, and families with children who lack a permanent place to live continuously for a year or more or at least four times in the past three years. Exclude any period of institutionalization, incarceration, or transitional housing when determining the length of time a household has been homeless.

Important! *Eligibility requirements for homeless status depend on the type of program.*

Households at Significant Risk of Long-Term Homelessness: Includes (a) households that are homeless or recently homeless that have members who were previously homeless for extended periods of time and are faced with a situation or a set of circumstances likely to cause the household to become homeless in the near future, or (b) previously homeless persons who will be discharged from correctional, medical, mental health or treatment centers who lack sufficient resources to pay for housing and who do not have a permanent place to live.

For more information, please read: LTH Definition Eligibility Common Questions found at mnhousing.gov.

Applicant Verification

I verify the information provided on this form is accurate and true.

Print Name: _____

Email: _____

Telephone Number: _____

Signature: _____ Date: _____

Service Provider Determination

I have determined that the applicant:

- ☐ Meets the definition of long-term homelessness
- ☐ Meets the definition of significant risk of long-term homelessness
- ☐ Does not meet either definition

Print Name: _____

Title of Professional: _____

Company/Agency Name and Address: _____

Telephone Number: _____

Fax: _____ Email: _____

Signature: _____ Date: _____

Start/End Dates	Type of Living Situation	City and State AND Facility Name OR Address	Reason for Leaving	Verification Type	# Months Homeless

Comments/Notes/Reason For Self-Certification

Rice County HRA Bridges Program
Verification of Serious Mental Illness

This form must be completed by a doctor or mental health professional. 1

Print Applicant Name: _____

☐ I hereby verify that the applicant **meets** the Minnesota Comprehensive Mental Health Act definition of having a serious mental illness.2

☐ I hereby verify that the applicant **does not meet** the Minnesota Comprehensive Mental Health Act definition of having a serious mental illness .ii

Documents to confirm this determination are contained in an applicant's case file.

_____
Print Name of Mental Health Professional

_____
License/Qualification of Mental Health Professional

_____
Telephone Number Fax

_____
Address City State Zip Code

_____
Signature of Mental Health Professional Date

Return this form to the following address:

Rice County HRA
Rice County Government Services Building
320 3rd Street NW
Faribault, MN 55021
Fax: 507-333-3838
Email: RCHousing@co.rice.mn.us

1 Mental Health Professional: A person providing clinical services in the treatment of mental illness who is qualified in at least one of

the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:

(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or

(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;

(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness

2 Minnesota Statute 245.462, subdivision 20, Mental illness. (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and **that seriously limits a person's capacity** to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.