Maine Department of Health and Human Services
Office of Behavioral Health
BRIDGING RENTAL ASSISTANCE PROGRAM (BRAP) APPLICATION

What is BRAP?
BRAP is a state-funded program that assists clients with Serious Mental Illness and a history of hospitalization, incarceration, and homelessness with obtaining transitional housing by providing rental assistance and support in finding independent housing.

BRAP is intended to serve as a bridge to more permanent housing options, such as Section 8. BRAP clients are required to contribute 40% of their income toward their monthly rent.

Where do I send my application?
Submit your application and all supporting documentation to the agency listed below serving the county where you wish to live if approved.

ANDROSCOGGIN, FRANKLIN, AND OXFORD COUNTIES

Sweetser

P.O. Box 1319 Lewiston, ME 04243

Tel. 207-294-4462 Fax: 207-294-4462 (Attn: Housing Subsidies)

YORK, CUMBERLAND, KNOX, LINCOLN, SAGADAHOC, AND WALDO COUNTIES

Shalom House, Inc.

106 Gilman Street Portland, ME 04102

Tel. 207-874-1080 Fax: 207-874-1077 (Attn: BRAP LAA) Email: brapapplications@shalomhouseinc.org

AROOSTOOK, HANCOCK, PENOBSCOT, PISCATAQUIS, AND WASHINGTON COUNTIES

Community Health & Counseling Services

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

Tel. 207-947-0366 Fax: 207-945-4465 (Attn: Rental Services) Email: rentalservices@chcs-me-org

KENNEBEC AND SOMERSET COUNTIES

Kennebec Behavioral Health

67 Eustis Parkway Waterville, ME 04901

Tel. 207-873-2136 Fax: 207-660-4532 (Attn: Rental Services) Email: rentalservices@kbhmaine.org

Before submitting your application, double check to be sure you have the following documents included:
- ☐ Completed application with all questions answered
- ☐ Specific Eligibility documentation (ATREZZO or BRAP Enrollment form completed)
- ☐ General Eligibility (Priority) documentation
- ☐ Social Security eligibility documentation
- ☐ Federally subsidized housing waitlist confirmation

What happens after I have submitted my application?
Once your application is received by our program, it can take up to 15 business days to process. Once your application is processed you will receive a letter in the mail that reflects one of the following: a notification of award, a notification of conditional award, a notice that the application is incomplete, or a notice of denial with further instructions. If you do not receive a response after 15 business days, please contact the agency you submitted to.

A. APPLICANT INFORMATION

First Name: _____ **Last Name:** _____

Gender: ☐ Male ☐ Female ☐ Transgender Other _____

Social Security Number: _____ - _____ - _____ **DOB**:_____/_____/_____

Veteran: YES ☐ **NO** ☐ **Are you Hispanic or Latino?** ☐ Yes ☐ No

Race (check all that apply):

☐ American Indian or Alaskan Native
☐ Black or African American
☐ White or Caucasian
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Other: _____

1. **What is the best way to get in contact with you?** (please check all that apply).

   Phone 1: ☐ _____
   Phone 2: ☐ _____
   Email: ☐ _____
   Mailing Address: _____

2. **Do you want us to copy all correspondence to your referral source or other service provider?** *If yes, please provide name, address, and phone number for all that apply.*

   Payee:_____
   Case Manager: _____
   Guardian: _____
   Service Provider: _____

3. **Do you have a preferred language, other than English?**

   (Specify):_____

   **An interpreter service is available upon request. Please notify the program if alternative methods are needed.*

4. **Household Composition:** Please list everyone who will be residing in the household.

Name:	Relationship to Applicant:	Pregnant?
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No
_____	_____	____ Yes ____ No

5. Household income & assistance sources: (*Please attach current verification of CURRENT income.)*

Income sources		**Assistance sources**
No financial resources	☐	☐ None
Supplemental Security Income (SSI)	$_____	☐ SNAP / Food Stamps
Social Security Disability Income (SSDI)	$_____	☐ Medicare
Social Security	$_____	☐ Medicaid (MaineCare)
Employment income	$_____	☐ SCHIP
General Public Assistance (GA)	$_____	☐ VA Medical Services
Unemployment benefits	$_____	☐ WIC
Temporary Aid Needy Families (TANF)	$_____	☐ TANF (Child Care / Transp.)
State SSI Supplement	$_____	☐ Indian Health Services
Other (List Source):_____	$_____	☐ Employer Provided Insurance
TOTAL Monthly INCOME:	**$_____**	☐ Other: _____

B. SPECIFIC ELIGIBILITY

1. Do you meet Eligibility for MaineCare Community Support Services, as defined in Section 17 of the MaineCare Benefits Manual?

YES ☐ **NO** ☐

2. Are you currently receiving SSI or SSDI, or have you applied, or are you actively appealing a denial? (*Please attach documentation)*

YES ☐ **NO** ☐

3. Are you currently, or will you be on a waitlist for federally subsidized housing, such as Section 8 or HCV? (*Please attach documentation)*

YES ☐ **NO** ☐

If 'No' why? _____

_____

C. GENERAL ELIGIBILITY

To be eligible for BRAP, applicants must also be experiencing an eligible situation. (*cont. on next page*)

Documenting Priority: Verification should include the start/end dates of qualifying situation(s), including dates, length of stay, and location/facility as applicable to each priority. Verification letters should be on an agency letterhead and signed by provider providing verification. *Examples of Priority verifications include, but are not limited to: Hospital discharge paperwork, Letter from Hospital Staff, Letter from Homeless provider, Letter from agency providing emergency assistance, Letter from Outreach Worker witnessing situation, Letter from ICM/Dept of Corrections, Release paperwork, etc.*

*****ALL APPLICANTIONS MUST INCLUDE VERIFICATION OF PRIORITY***

Current BRAP Priorities *(as of 8/25/2026)*
Please Select Priority under which the applicant is applying. (*Only choose one*)

☐ **Priority 1: Psychiatric Discharge after seventy-two (72) hour or greater psychiatric inpatient hospital admission**

a. Individuals who are being discharged, or were discharged within the past thirty (30) days from:
   - Riverview Psychiatric Center or Dorothea Dix Psychiatric Center, or;
   - A private psychiatric hospital or facility, or;

b. Individuals who are moving from a Community Residential Treatment Program (Mental Health PNMI) to less restrictive accommodations to allow for appropriate discharges, as determined by their clinical support team.

☐ **Priority 2: Release after 30 days or greater from a Correctional Facility**

Individuals who were incarcerated for at least thirty (30) days or more and are scheduled for release from a Correctional Facility within the next thirty (30) days, or released within the past thirty (30) days, and:
- Has no subsequent residences identified, or;
- Have been adjudicated through a Mental Health treatment court.

☐ **Priority 3 Literal Homelessness, as defined by HUD**

An individual or family who:

- Lacks a fixed, regular, and adequate nighttime residence, meaning: Has a primary nighttime residence that is a public or private place not meant for human habitation; **or**
- Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); **or**
- Is exiting an institution (i.e., incarceration, hospitalization) where they have resided for 90 days or less and who were homeless before entering that institution.

Applications received under Priority 3 are ranked according to length of homelessness, with those being homeless the longest as the top priority.

For Priority 3, please include all known dates/locations that the provider has witnessed the living situation, with the most recent being within 14 days of application submission.

☐ **Priority 4 Discharge from a Certified Recovery Residence**

An Applicant who is residing in and will be exiting a certified recovery residence within the next thirty (30) days, and have no subsequent residence identified.

Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station – 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), 1-800-606-0215 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.



Applicants are encouraged but not required to engage in services as a condition of acceptance into the Bridging Rental Assistance Program.

APPLICANT CERTIFICATION (*must be signed by applicant and/or guardian*):

I/We certify that the information contained in this application is true and complete to the best of my/our knowledge and belief.

Print Applicant Name	Applicant Signature	Date
Print Name–Other Adult Member	Other Adult Member Signature	Date

PROVIDER REFERRAL (*only needs to be filled out if application is being submitted by provider***):**

Eligibility verification and certification

I hereby affirm the above-enclosed information concerning current housing situation, current address, and eligibility criteria are true and accurate for this client as indicated above; and I verify the Applicant meets the Eligibility for Care for Community Support Services **or** Private Non-Medical Institutional Services as defined in Section 17 and Section 97, Appendix E of the MaineCare Benefits Manual.

CHECK APPROPRIATE BOX and ATTACH VERIFICATION:

☐ Applicant is already enrolled in Community-Based Support (Section 17) **or** PNMI (Section 97) Services— *please attach ATREZZO documentation showing current, active enrollment.*

OR

☐ Applicant is qualified for, but not currently enrolled in Section 17 or Section 97 appendix E services. — *please attach completed BRAP Enrollment Form (Appendix A).*

Referring Agency: _____

Printed Name	Signature	Date

APPENDIX A

Office of Adult Mental Health Services

BRAP ENROLLMENT FORM

To be completed ONLY for applicants not already enrolled in Section 17 or 97 Services AFTER April 7, 2016

Client Information:

Name: _____

Date of Birth: _____

Social Security Number: _____

Diagnosis and LOCUS Information:

Primary Diagnosis : _____

Date Given: (within 12 months):_____

LOCUS Score:_____Rater ID:_____

Date Given (within 12 months):__ _____

Requirements for Eligibility. A person is eligible to receive covered services if he or she meets both general MaineCare eligibility requirements and specific eligibility requirements for Community Support Services under Section 17 of the MaineCare Benefits Manual.

General Requirements. Individuals must meet the eligibility criteria set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and number of services they are eligible to receive.

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 TR diagnosis.

Specific Requirements. A member meets the specific eligibility requirements for the services covered 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 TR criteria; or
2. Another primary DSM 5 TR diagnosis or DSM 4 equivalent diagnosis **with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders** who:
   a) have 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 TR 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 TR diagnosis; or
   c) has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 TR 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 TR 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

B. Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the LOCUS 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.

History Of (check all which apply):

- ☐ Has received treatment in a state psychiatric hospital, within the past 24 months;
- ☐ Has been discharged from a mental health residential facility, within the past 24 months;
- ☐ Has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months;
- ☐ Has been committed by a civil court for psychiatric treatment as an adult;
- ☐ Until the age of 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 TR diagnosis, that would result in or have significant risk factors of (check all which apply):**

- ☐ Homelessness;
- ☐ MH Residential treatment;
- ☐ MH inpatient greater than 72 hours;
- ☐ 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 diagnostic
Clinician Name (printed)
information listed on the previous page (6) are in accordance with the 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.

_____
Provider Signature and Credentials ***(must be MD, LCSW, LCPC, PhD, APRN, NPC, PA or DO)***

Date:_____