FY ‘25

WRAP FUND

APPLICATION

PACKET

(REVISED 04/03/2024)

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) 945-4465

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:

Nicole Cohen	or	Heather Salib
CHCS		CHCS
42 Cedar Street		42 Cedar Street
Bangor, ME 04401		Bangor, ME 04401
(207) 922-4600, ext. 6313		(207) 922-4600, ext. 6382
ncohen@chcs-me.org		hsalib@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.

For Agency Use Only	
Date Received	
Application complete	
Application incomplete	

Adult Mental Health
Office of Behavioral Health
Wrap-fund Application

Penobscot, Piscataquis,
Hancock, Washington

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 :____

Agency Name & Relationship:____

Signature of person completing form :____

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 Acentra Health Atrezzo®;

Is Applicant currently enrolled in Adult Mental Health Services funded Community Support Services (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 Acentra Health 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 Acentra Health 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 <u>not already</u> in Section 17 services.

A Clinician is an individual appropriately licensed or certified in the state or province in which he or she practices, practicing within the scope of that licensure or certification, and qualified to deliver treatment under this Section. A qualified professional with one of the following credentials: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker-conditional (LMSW-conditional clinical); physician, psychiatrist; Psychiatric and Mental Health Nurse Practitioner (PMH-NP); Psychiatric and Mental Health Clinical Nurse Specialists (PMH-CNS); Adult Nurse Practitioner (ANP); Family Nurse Practitioner (FNP); Physician Assistant (PA); or licensed psychologist.

I hereby affirm the below-enclosed information concerning the current situation, current address, and eligibility criteria are true and accurate for this client in the Wrap Section 17 eligibility form and application.

1. I verify the Applicant meets the Eligibility for Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual.

Client Information	Diagnosis Information
Name:	Primary Diagnosis:
Date of Birth:	Date Given:
Social Security number:	

<u>Specific Eligibility Requirements</u>.

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

A. The person is age eighteen (18) or older or is an emancipated minor with:

1. A primary diagnosis of Schizophrenia or Schizoaffective disorder in accordance with the DSM 5 criteria; or
2. Another primary DSM 5 diagnosis or DSM 4 equivalent diagnosis with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders who:
   a) Has a written opinion from a clinician, based on documented or reported history stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homelessness, criminal justice involvement or require a mental health inpatient treatment greater than seventy-two (72) hours, or residential treatment unless community support program services are provided; based on documented or 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, 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.

<u>Risk Factors</u>: Documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis.

History Of (check all which apply):

- ☐ Has received treatment in a state psychiatric hospital, within the past twenty-four (24) months;
- ☐ Has been discharged from a mental health residential facility, within the past twenty-four (24) months;
- ☐ Has had two (2) or more episodes of inpatient treatment for mental illness, for greater than seventy-two (72) hours per episode, within the past twenty-four (24) months;
- ☐ Has been committed by a civil court for psychiatric treatment as an adult;
- ☐ Until the age twenty-one (21), the recipient was eligible as a child with severe emotional disturbance.
- ☐ If selecting this qualifier, please indicate a written opinion stating that the recipient, in the last twelve (12) months, had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

Based on documented or reported history**, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of (check all which apply):

- ☐ Homelessness
- ☐ Require a mental health inpatient treatment greater than seventy-two (72) hours
- ☐ Residential treatment unless community support is provided
- ☐ Criminal Justice involvement

**Reported history may include oral or written history from the client, a provider, or a caregiver.

Signatures and Certifications:

I certify and attest that the attached verifications, diagnostic information including LOCUS score are in accordance with Specific Requirements section of this form Part A, paragraph 2, sub paragraph a) and is true and complete to the best of my knowledge and belief.

____ ____________________

Clinician Signature/Credentials **Date**

(LCPC); (LCPC-conditional); (LCSW); (LMSW-conditional clinical); physician, psychiatrist; Psychiatric and Mental Health Nurse Practitioner (PMH-NP); Psychiatric and Mental Health Clinical Nurse Specialists (PMH-CNS); (ANP); (FNP); (PA); or licensed psychologist.)

____

Printed Name and Credentials

Section 2 - FINANCIAL

Each Wrap -fund application includes all household income, assets and benefit resources.

What is your current household monthly income?

Source	Applicant	Family Member 1	Family Member 2	Family Member 3
Social Security Income	$	$	$	$
Public Assistance Payments (TANF, GA,LHEAP etc.)	$	$	$	$
Employment	$	$	$	$
Rent paid by Housing Subsidy (BRAP, Permanent Supportive Housing, Section 8, HUD- VASH 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 ☐ No ☐
2a	If no, would you like help from the Bureau of Veteran Services to apply for VA benefits? Yes ☐ No ☐
2b	If yes, please complete a Authorization to Release Information form from your Case Management Agency to authorize ____________________ (Insert Agency Name) to release information to Bureau of Veteran Services The On line request form can be access at https://www.maine.gov/veterans/docs/MBVS-Request-Form-Online-Fillable.pdf or Field office locations https://www.maine.gov/veterans/veterans-services-offices/locations/index.html

What are your current household monthly expenses?

Category	**Household Expenses**	**Category**	**Household Expenses**
Total Cost of Rent/Mortgage Payment/Lot Rent		Other Necessary Expenses (list):	
Alimony Paid			
Child Support Paid			
*Transportation Expense			
**Heating Expense			
**Electric Expense			
**Water & Sewer			
Telephone/ Cell Phone /Internet/ Cable (circle)			
Total		**Total**	

GRAND TOTAL OF ALL HOUSEHOLD EXPENSES: $____________(add both Household Expense columns)

*** Transportation** expenses include payment, fuel, maintenance, inspections/tags, and insurance.

*** Public** *transportation can be listed under other necessary expenses.*

****** If heating, electric, water and sewer is included in rent, write **INCLUDED**.

If no monthly expense is reported, please explain this circumstance:

Are you behind in any of your bills? Yes ☐ No ☐. If yes, please explain:

Verification of other resources (i.e. General Assistance, Section 8 housing, LHEAP, Salvation Army, Religious Organizations etc.).

Must list at least two other resource(s) you have tried. If applying for any housing assistance, the Applicant must have contacted general assistance, and been denied, prior to applying for Wrap funding.
List name of organizations or /agencies, date of contact date applied hone number and outcome (approval or denial to receive resource).

Organization/Agency	Phone Number	Date Applied	Outcome of Request

Section 3 – Request for Assistance

Is this an emergency need? Yes ☐ No ☐

If **NO**, you are not eligible for Wrap funds

If **YES**,

1) Please provide as much detail as possible as to why you are requesting WRAP Funding, and
2) Explain how this will resolve the emergency need.

Use an additional sheet and attach to application if needed. The requests are reviewed by Wrap fund committees that do not know you and your circumstances behind the need. The most current and concise information you can provide will be helpful.

___
___
___
___
___
___
___
___
___

Section 3-Request for Assistance continued

Applicant to complete Wrap Fund Category. Please select category and include amount of request and any other required documents.
Applicant must provide Vendor Tax ID with Wrap Application

** Funds may be used for one (1) need below per State fiscal year per Applicant for. Applicant cannot apply for additional Wrap -funds until the start of the next state fiscal year.

_______*__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).

Please Note:
Eligible Applicants must be named on the lease, that have additionally provided the following with their Wrap Funds application:

- Documented verification that State, Federal, and local housing subsidies have been applied for;
- Documented verification that a Bridging Rental Assistance Program (BRAP) or Permanent Supportive Housing application has been applied for;
- Documented verification that the Wrap Funds Applicant is the primary lease holder for the location for which Wrap Funds are being requested for;
- Documented verification of the Fair Market Rent (FMR) or Payment Standard for that area, and the number of bedrooms for all security deposits and rent requested via Wrap Funds.

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

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

_____________ # of bedrooms _____________________ City/town of housing

_______*__Rent Assistance__ (*must provide eviction notice or documentation of what is currently owed*; not to exceed one month's Fair Market Rent as published by the U. S. Department of Housing and Urban Development).

Please Note:
Eligible Applicants must be named on the lease, that have additionally provided the following with their Wrap Funds application:

- Documented verification that State, Federal, and local housing subsidies have been applied for;
- Documented verification that a Bridging Rental Assistance Program (BRAP) or Permanent Supportive Housing application has been applied for;
- Documented verification that the Wrap Funds Applicant is the primary lease holder for the location for which Wrap Funds are being requested for;
- Documented verification of the Fair Market Rent (FMR) or Payment Standard for that area, and the number of bedrooms for all security deposits and rent requested via Wrap Funds.

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

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

_____________ # of bedrooms _____________________ City/town of housing

________* **Electric bill**
Only provide Wrap Funds for an "Electric bill to maintain power in the Applicant's residence, in the case of an emergency" not to exceed $500. Prior electric bills may be considered as long as it does not exceed one year from date of application. Additionally:

- 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;
- The Applicant must provide a copy of an approved payment plan from power vendor for remaining amount and attach to the Wrap -fund application.
- The Applicant must provide a copy of the prior electric bill (no more than one year old) with Applicant's name and supporting documentation that past due electric bill is preventing the Applicant from moving into a permanent, safe and secure housing.
- 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__ (heating oil, Kerosene, propane, pellets (for pellet stove), or firewood Not to exceed $500. Additionally:

- 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. Include dates of applications for heating assistance.
- Applicant to verify that it is the Applicant's obligation to pay for fuel under a lease/occupancy Agreement under the Applicant's name.
- Wrap funds do not cover portable or disposable heating devices, such as propane cylinders and electric heaters.

_______ *__Vision /Eye Care__-not to exceed $500 (Please attach eye glass prescription, estimate and/or bill for eyeglasses/ vision exam in applicant's name from the provider)

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

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

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

- If denture costs are over $1000 please refer applicant to Community Dental Services; an OBH granted funded program for no cost dental services.

_______ *__Transportation to include car repairs and transportation to access mainstream services__-not to exceed $500 (Please attach estimate of repair cost).

- Please attach car repair estimate from certified car mechanic. Car repairs can be completed by consumer 's choice of vendors.
- Verification that the Applicant, is the named owner of the vehicle, and has current vehicle insurance and current vehicle inspection;
- Provide documentation that transportation is needed to access a Mainstream Resource, length of time transportation is needed, mileage and cost of transportation to include (2) estimates.
- Provide documentation that MaineCare will not cover cost of transportation to Mainstream Resources.

- Wrap will not pay for vehicle repairs that exceed 60% of the vehicle's current Kelley Blue Book value.

_______ ***Other Emergency Need** -not to exceed $500 (Please attach estimate)
Please describe "Other Emergency Need":

____

____

_______ ***Emergency Need as referred by the Department**

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

Please note that Wrap funding will not pay for: temporary stays in a hotel or motel, prescription medications telephone or cell phone payments, purchasing entertainment electronics (to include: laptops, televisions, cell phones , electronic tablets, etc.) vehicle payments, vehicle insurance, cable/streaming/internet service bills; mental health treatment or services, substance use disorder treatment or services, evaluations or assessments, any legal services/representation/lawyer fees, additional funding stream for contracting agencies, no pet related expenses, including therapy animals, shall be reimbursed under this contract; Court ordered DEEP or offender treatment; car repairs which exceed sixty percent (60%) of the vehicle's Kelley Blue Book value, or when other transportation resources are available; debt consolidation or credit counseling services; owed property taxes to municipalities, and household/immediate family member's mortgage/rent payments, utility bills or other personal debts. Travel or passport expenses are not authorized.

Section 4- Applicant and Committee Checklist

For each application, the **Wrap -funds Applicant <u>and</u> Committee** must answer "YES" to the following five (5) criteria for Wrap -funds to be approved:

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

Note: All approved applications requests for Wrap funds must fall under the following Wrap Fund categories and Wrap -fund Allowable Amounts as described above.

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:	$
Community Health and Counseling Services 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, CHCS is willing to pay the indicated CHC S 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, su bject 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 la wfully be applied to retention of a security deposit for residential premises.

AGREED BY LANDLORD:

By:

Signature:
Date:
Printed Name:
Title:

*Please complete this form as well as a W-9.

VENDOR INFORMATION FOR ALL REQUESTS THAT ARE NOT SECURITY DEPOSITS:

Check Payable To:
Mailing Address:
Phone Number:
Federal Tax ID # or Social Security Number:

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

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 accounts payable at (207) 922-4600, ext 6501 or accountspayable@chcs-me.org.

Sincerely,

Accounting Clerk

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)

APPENDIX A

Office of Behavioral Health
Wrap Appeal Form

The Wrap Fund program recognizes that an Applicant may not agree with a Wrap Fund Committee's decision. In these cases, the Applicant has the right to appeal. Any individual filing an appeal has the right to have a designated representative or advocate throughout the entire process.

Because Wrap Funds are not an entitlement, application denials are challenged through the process described below, rather than through the grievance process outlined in the Rights of Recipients of Mental Health Services.

A consumer who disagrees with a decision about his or her Wrap Fund application may appeal the determination by filing a written appeal within thirty (30) days of decision by the Agency.

Date of Appeal Submission:
Name of Applicant:

The following shall be included, to be considered a complete appeals packet:
☐ The Wrap-fund Appeal Form;
☐ Wrap Fund Denial Letter;
☐ Updated correspondence from the Applicant;
☐ Current copy of the completed Wrap Fund Application;
☐ Release of Information for OBH; and
☐ Any documentation submitted with the application to the Provider.

Provider Signature __________________________ Date: ______________

Applicant Signature___________________________ Date: ______________

The OBH Mental Health Treatment Division Manager or designee will convene an appeals committee. An Appeals committee will consist of a minimum of three (3) members, to include one (1) consumer as a member. A quorum of three (3) will be required to determine the outcome of the appeal.

The OBH Mental Health Division Manager or designee will conduct an investigation and provide a written response to the Applicant within ten (10) working days from the date the appeal was received. The OBH Mental Health Division Manager or designee may request an extension of an additional five (5) working days if necessary and will contact the Applicant if an extension is needed.

The determination from the DHHS OBH Appeals committee is final.

Please submit Wrap Appeal Packets by confidential/Secure email to:
Brianne.Masselli@maine.gov , and
Cynthia.McPherson@maine.gov
OBH Mental Health Treatment Division Manager; or designee
41 Anthony Ave, #11 SHS,
Augusta, ME 04333-0011