Office on Mental Health/Core Service Agency of Harford County, Inc.
125 N. Main Street/Rear Entrance, Bel Air, MD 21014
Phone: 410-803-8726 Fax: 410-803-8732

APPROVED ☐
DENIED ☐

Application for Consumer Support Assistance

☐ Eviction Prevention ☐ Security Deposit ☐ Utility Assistance ☐ Other_____

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

Applicant's Name: _____ **SS#** _____ **DOB:** _____

Applicant's Address: _____ **Phone Number:** _____

Provider making request: _____

Today's Date: _____ **Email address for person making request:** _____

Agency Name & Address: _____

Agency Phone: _____ **Agency Fax:** _____

Primary Diagnosis: _____**Diagnosing Source:** _____ **Phone Number:** _____

Household Members Name & Age	Monthly Income Amount & Source

Type of Expenses	Average Monthly Expense
Rent	
Gas/Electric	
Water	
Phone	
Transportation	
Cable	
Food	
Other	
Monthly Total:	

Please note: All required documents must be included with the request before it will be considered. If the documentation is not attached, the request will be returned to the referral source with a letter identifying the missing documentation.

For Evictions	For Security Deposits	For Utilities	For Other
• Copy of request **AND** • Copy of eviction notice and/or letter from landlord	• Copy of request **AND** • Welcome letter or unexecuted lease from landlord with requested amount included	• Copy of request **AND** • Recent BGE statement (30 days) **OR** • Statement to continue or restore services	• Copy of request **AND** • Copy of bill, invoice, receipt (documentation to validate request)

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Describe prior eviction(s) and/or utility turnoff history and what led to this request:

_____
_____
_____

What is the financial plan to prevent future requests?

_____
_____
_____

How does this request alleviate a problem related to the individual's behavioral health?

_____
_____
_____

Agency Name: (THREE OTHER RESOURCE ATTEMPTS MUST HAVE BEEN MADE)	Date Contacted:	Name of Contact:	Outcome:
Harford Community Action Agency			

Does applicant have Medicaid? Y/N If no, please submit Documentation of Uninsured Eligibility Form

Amount Requested from Office on Mental Health/CSA: $_____ (CAN NOT EXCEED $500)

Amount Applicant Will Pay: $_____

Amount from other resources: $ _____

Total: $ _____ (Must total amount of assistance needed)

Vendor/Landlord Name and Address: _____

Vendor/Landlord Telephone and Fax: _____

Please make check payable to: _____

*******FOR CSA USE ONLY*******

Date Received: _____ OMH/CSA Authorization Code: CSAHC_____

Approved □ Amount: $_____

Denied □ Reason: _____

Signature: _____ Date: _____

Signature: _____ Date: _____