

APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/>
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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.

<p>For Evictions</p> <ul style="list-style-type: none"> • Copy of request AND • Copy of eviction notice and/or letter from landlord 	<p>For Security Deposits</p> <ul style="list-style-type: none"> • Copy of request AND • Welcome letter or unexecuted lease from landlord with requested amount included 	<p>For Utilities</p> <ul style="list-style-type: none"> • Copy of request AND • Recent BGE statement (30 days) OR • Statement to continue or restore services 	<p>For Other</p> <ul style="list-style-type: none"> • Copy of request AND • Copy of bill, invoice, receipt (documentation to validate request)
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**Office on Mental Health/Core Service Agency of Harford County, Inc.
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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: _____