RECOVERY REQUIRES A COMMUNITY PROGRAM APPLICATION

Please keep in mind that ***you only need to fill out sections for which you are requesting funding***. However, you are required to always send the Basic Information section, as well as the Final Calculation and Attestation.

Required Supplemental Information:

- ☐ Release of Information, signed by the individual or legal guardian (when applicable). A signed ROI must be on file prior to transition from the institution (such as a nursing home or residential treatment facility).
- ☐ Documentation of Behavioral Health Diagnosis (mental health or substance use disorder)
- ☐ Quotes or Cost Estimates (when applicable – minimum three bids required for home modifications)

For assistance with completing this application, please contact Recovery Requires a Community by phone at 614-644-0617, or email recovery@mha.ohio.gov.

Please submit this application and all supporting documents via email to recovery@mha.ohio.gov or fax to 614-488-4504 prior to the individual's discharge from the nursing facility.

Demographic Information

Individual's Name:	**Medicaid ID #:**
Date of Birth:	**Social Security #:**
Gender: ☐ Male ☐ Female ☐ Other	**Name and Address of Current Facility:**
Legal Guardian Name, Phone, Address (when applicable)	**Anticipated Transition Date (MM/DD/YYYY):**
Estimated Monthly Income Upon Transition:	**Contact Information Upon Transition:**
Pre-Transition Case Manager (Name and Phone):	**Transition Coordinator (Name, Phone, Agency):**
Diagnostic Information: **Axis I:** **Axis II:**	

Application Index – Page 1, Page 2 Resource Checklist, and Page 5 must be completed for all categories of assistance.

For Housing Assistance *Page 2*
For Utility Assistance *Page 3 (top half)*
For SILA *Pages 3-4*
For Other Non-Categorized Needs *Page 4 (bottom half)*

Individual Resource Checklist *Please indicate which of these linkages have been facilitated as part of the transition.*	
Residential State Supplement (RSS)	☐ Date (MM/DD/YYYY): _____
Tenant-Based Housing Voucher	☐ Date (MM/DD/YYYY): _____
Home Energy Assistance Program (HEAP) and/or Percentage of Income Payment Plan (PIPP)	☐ Date (MM/DD/YYYY): _____
Community Behavioral Health Agency	☐ Date (MM/DD/YYYY): _____
Ohio Dept. of Job and Family Services (ODJFS) (Income Verification & Food Assistance)	☐ Date (MM/DD/YYYY): _____
HOME Choice (Ohio Department of Medicaid)	☐ Date (MM/DD/YYYY): _____
Home Health Services	☐ Date (MM/DD/YYYY): _____

Housing Assistance

1. Please rank the following housing types from one to four (1-4) where one (1) means it is most preferred housing & four (4) means it is least preferred. *Each number may be used only once.*		2. What is the amount of rent for the unit?
Housing Choices	**Rank**	3. Has someone visited the housing and deemed it safe and accessible for the individual?
A. Live in a house, apartment, or room by yourself		
B. Live in a house, apartment, or room with family		
C. Live in a house, apartment, or room with roommate(s)		4. If housing has been selected, what is the address of the unit?
D. Live in a group setting (Adult Care Facility)		

Budget & Calculation

Line Number	Budget and Calculation	Amount
1	Individual's current monthly gross income (rounded to nearest dollar)	
2	Required amount individual will pay toward rent: Please multiply amount in line 1 by 0.30 (30%).	
3	If known, please enter the amount of rent here. If unknown, mark "n/a" and use only the Fair Market Rent calculation.	
4	Fair Market Rent: Please refer to this document for current Fair Market Rents. If this number is smaller than #3, please enter it here.	
5	Amount per month of Recovery resources needed: Please subtract the amount from line 2 from the smaller amount from Line 3 or 4.	
6	Multiply the amount in Line 5 by the number of months needed:	
TOTAL	*Please enter this amount on the final page of the application:*	

Utility Assistance

Note: Recovery Requires a Community may be able to assist with one-time payment of utility arrears or temporary assistance with utility payments.

Utility Assistance Checklist	
□Arrears or □Temporary Assistance Type: □ Gas □Water □Electric Company: _____	
Please indicate which resources have been utilized related if a debt is described:	
☐	Legal Aid (for non-utility debts)
☐	Credit Counseling
☐	Balance Negotiation with Involved Company

Budget & Calculation

1. What is the current remaining debt or need presenting as a challenge to the individual's transition?

Source	**Amount (rounded to nearest dollar)**
TOTAL: *Please enter this amount on the final page:*	

Supplemental Independent Living Assistance

Note: SILA services assist in the development of skills needed for sustainable community living. Recovery Requires a Community may assist in paying for these supplemental services *when they are clearly shown to benefit applicants and help them stay in the community* as long as other resources (such as HOME Choice) have already been pursued**.** Additionally, this may cover services that an individual would receive via Home and Community Based Waiver, but may have a gap in service provision.

Checklist

Which services are you requesting for the individual?

☐Independent Living Skills Training	☐Community Support Coaching	☐Social Work/Counseling
☐Nutritional Consultation	☐Homemaker/Personal Care	☐Other: _____

1. Please explain how this service will support the individual and contribute towards sustainability in the community.

2. Has the individual applied for waiver services?

   ☐Yes ☐No

If so, is there an expected gap in service provision?

☐Yes ☐No

3. Please select what other options have been pursued to provide a similar service:

☐Peer Support ☐Faith-based Community ☐Senior Center ☐Other: _____

Budget and Calculation

Service	Rate	Hours Requested (MAX)	Total $ Requested
☐ Independent Living Skills Training	$30.00/hr.	(144)	
☐Community Support Coaching	$25.00/hr.	(72)	
☐Social Work/Counseling	$64.12	(36)	
☐Nutritional Consultation	$52.56	(36)	
	TOTAL	*Please enter this amount on the final page:*	

Other

Note: Because of its broad scope, the "Other" category requires more coordination between Recovery Requires a Community staff and a transition planning team in order to make sure that all possible resources have been exhausted in the local community. **Please consider and address below whether all other resources of possible benefit have been pursued to provide this need.**

Checklist

Goods & Services	☐
Transportation	☐
Home Modifications (Three bids attached)	☐
Other (Please specify below)	☐

1. Based on the indications above, please provide additional detail regarding the nature of the request. What has been done up to this point in order to try to provide resources for that need?

Budget & Calculation

1. Please fill out this table, indicating the amount of hours requested (if applicable), and the total amount of money indicated.

Service	Total $ Requested
TOTAL: *Please enter this amount on the final page:*	

Please provide additional information that may help with reviewing this individual's application:

Final Calculation & Attestation

Total Request to Recovery Requires a Community
Take the totals from each category and list them below:

Category	Money Requested ($)
Housing	$
Utility Assistance	$
Supplemental Independent Living Assistance	$
Other	$
TOTAL:	

By voluntarily signing this form, I hereby declare, certify and affirm that the information I have provided on this application, including all attachments and supporting documentation, is true and accurate to the best of my knowledge and belief.

_____ _____ _____
Applicant Name Applicant Signature Date (MM/DD/YYYY)

By voluntarily signing this form, I hereby declare, certify and affirm that the information I have provided on this application, including all attachments and supporting documentation, is true and accurate to the best of my knowledge and belief. Providing any misleading information, or engaging in fraudulent activities will result in my agency providing repayment of Recovery Requires a Community funds to the Ohio Department of Mental Health and Addiction Services, and will also forfeit my agency's ability to receive additional Recovery Requires a Community funds in the future.

_____ _____ _____
Provider Agency Name Staff Member Representative Date (MM/DD/YYYY)