ALCOHOL, DRUG ADDICTION, & MENTAL HEALTH SERVICES BOARD OF CUYAHOGA COUNTY
RESIDENTIAL ASSISTANCE PROGRAM (RAP) APPLICATION

Client must be enrolled and have a GOSH ID number. Client must be approved for RAP before discharge from the hospital, nursing home or jail. The ADAMHS Board requires five working days to process this RAP application. The Board will not pay for placement prior to approval. Please fill out clearly and completely and submit this application with all supporting documentation via email to RAPapplications@adamhscc.org.

GENERAL CLIENT INFORMATION

Last Name:		
First Name:		
Date of Application:		
GOSH ID (required):		
Date of Birth:		
Social Security #:		
Currently in RAP?	Yes	No
First time in RAP?	Yes	No

CLIENT LOCATIONS / ADDRESSES

Current Location:	
Address:	
City, State, Zip:	
Dates of Stay:	from ____________ to ___present_____
Prev. Location:	
Address:	
City, State, Zip:	
Dates of Stay:	from ____________ to ______________

CLIENT FINANCIAL INFORMATION

Required: Submit Social Security paperwork documenting this Client's monthly Social Security Benefits.

Current SS benefits:	$ / month
Current SSI benefits:	$ / month
Current SSDI benefits:	$ / month
Received SS benefits in the past?	Yes No

If Client receives Social Security benefits, CPST must apply for the RSS Program and submit a copy of the RSS Application with this RAP Application.

COMMUNITY MENTAL HEALTH PROVIDER AGENCY

Agency Name:	
Address:	
City, State, Zip:	
CPST name:	
CPST phone:	
CPST email:	
Supervisor name:	
Supervisor phone:	
Supervisor email:	

If no income, Client / CPST / Entitlement Specialist will apply for SS benefits on ________/________/_________

TO RESIDE AT ADULT CARE FACILITY (ACF)

ACF Name:	
License #:	
Rent/Fee:	$1,600.00
Operator Name:	
Address:	
City, State, Zip:	
Phone #:	
Desired Move-in Date:	

PAYEE / GUARDIAN INFORMATION

Required: Submit the latest 3 months Transaction Report from the Payee or Guardian detailing Client's income & expenses.

☐ *Check box if Client has no Payee/Guardian.*

Name:	
Agency:	
Address:	
City, State, Zip:	
Phone #:	
Email:	

REASON FOR CLIENT'S REFERRAL TO THE RAP PROGRAM

Please describe in detail the necessity for admission to a Class Two Residential Facility (ACF):

ACF MONTHLY FEE: $ **MAKE CHECK PAYABLE TO:**

ACF Operator Name:	
Address:	
City, State, Zip:	

CLIENT NEEDS MONTHLY PERSONAL SPENDING ALLOWANCE (PSA) OF $200? YES NO
(CHECK 'NO' IF CLIENT IS RECEIVING SS BENEFITS.) IF YES, MAKE CHECK PAYABLE TO:

Name:	
Address:	
City, State, Zip:	

REQUIRED SIGNATURES

Client / Guardian Signature:	Date:
CPST Signature:	Date:
CPST Supervisor's Signature:	Date:

ALCOHOL, DRUG ADDICTION, AND MENTAL HEALTH SEVICES BOARD
OF CUYAHOGA COUNTY
RESIDENTIAL ASSISTANCE PROGRAM

(RAP) LOAN PAYBACK AGREEMENT

Under this Agreement, all funds provided by the Alcohol, Drug Addiction, and Mental Health Services Board of Cuyahoga County (ADAMHS Board) RAP Program are a Loan which the undersigned Client agrees to pay back. This Agreement can apply to those with insufficient income to cover their start-up costs pending receipt of SSI, SSD, or RSS.

The undersigned Client agrees to pay back $10.00 no later than the 15th of each month, to the ADAMHS Board for repayment of the Loan. This payment will begin 30 days after admission into the Adult Care Facility.

Furthermore, the undersigned Client agrees to promptly pay back to the ADAMHS Board any and/or all lump sum monies or overpayments awarded from the Social Security Administration and/or the Department of Ohio Mental Health and Addiction Services (OhioMHAS) Residential State Supplement program.

Additionally, the undersigned Client agrees to notify the ADAMHS Board RAP Program immediately of any changes in income or resources, which could alter the monthly RAP payment amount. Failure to immediately provide the ADAMHS Board with information pertaining to any and/or all lump sum payments, or monthly payments from any source of income, including but not limited to the Social Security Administration, will result in the Client's termination from the RAP Program.

REQUIRED SIGNATURES

____/________________
Client / Guardian Signature Date

____/________________
CPST Worker Signature Date

____/________________
CPST Supervisor Signature Date

RESIDENTIAL ASSISTANCE PROGRAM

NOTARIZED STATEMENT CONCERNING FINANCES

Client has or has had Social Security income? ☐ YES ☐ NO

Client has a bank account? ☐ YES* ☐ NO

*If yes, submit the three most recent bank statements

Client Name: ___________________________

Client Signature: _________________________ Date: ____/_____/_____

CPST Name: ____________________________

CPST Signature: __________________________ Date ____/_____/_____

Notary Public: ___________________________ Date: ____/____/_____

Notary Stamp/Seal: