On Waitlist ☐ **YES** ☐ **NO**
Date Accepted: _____

On Program ☐ **YES** ☐ **NO**
Program Start Date: _____

BRAP waiver/status change form

Name of Applicant: _____ Date of Request: _____

DOB: _____ LAA: _____

Phone: _____ Fax: _____ E-mail address: _____

Does applicant meet one of the four priorities? ☐ YES ☐ NO

If YES, please indicate which priority:

☐ #1 Applicant is leaving a state institution (Dorothea Dix & Riverview) or private psychiatric hospital bed, or has been discharged within the last six months from any of these institutions
☐ #2 Applicant is homeless as defined by US Department of Housing and Urban Development (HUD)
☐ #3 Applicant is living in substandard housing as defined by HUD
☐ #4 Applicant is moving from a community residential program, funded by DHHS, to a more independent living arrangement

Does applicant meet eligibility for Section 17? ☐ YES ☐ NO
Is the applicant receiving SSI/SSDI benefits? ☐ YES ☐ NO
If 'NO' Why: _____
Does applicant have an active application with a Section 8 Public Housing Authority or Agency? ☐ YES ☐ NO
If 'NO' please choose appropriate waiver code below.

WAIVER:

☐ 1. Extension of 24-month maximum stay (LAA authorization only)
☐ 2. Use of General Assistance and/or Income other than SSI/SSDI (LAA authorization only)
☐ 3. No priority rating**
☐ 4. Section 8 Waitlist is closed
☐ 5. Approval to move to top of agency BRAP Wait List**
☐ 6. Immediate funding allocation**
☐ 9. Other** Reason: _____

**** DHHS approval is necessary**

Approval Conditions (please be specific): _____

_____

_____

I understand the above terms and conditions of this exception within the BRAP Program. Failure to comply with the terms and conditions of this agreement and the terms of the Bridging Rental Assistance Program (BRAP) may result in the termination of assistance.

Head of Household (Tenant) Signature: _____ Date: _____

Authorizing LAA: _____ Date: _____

DHHS Use Only:

Disposition of Request: ☐ Approved ☐ Conditionally Approved ☐ Denied
Funding authorized? : ☐ YES ☐ NO

Signature: _____ Date: _____
OAMHS Representative