Region 6 Behavioral Healthcare

Rental and Utility Assistance for Individuals with Opioid Use Disorder (OUD)

This program provides one-time rental and utility assistance to eligible individuals with Opioid Use Disorder to support housing stability and recovery.

About the OUD Assistance Program

Region 6 Behavioral Healthcare (Region 6) is launching a new housing assistance program to help individuals with Opioid Use Disorder (OUD) maintain stable housing by providing one-time payments for eligible rental and/or utility expenses. The program serves individuals residing in Cass, Dodge, Douglas, Sarpy, and Washington counties in Nebraska.

Eligible requests may include rental or utility expenses listed in this application packet, up to a maximum of **$4,000**. Assistance is limited to actual expenses and must be supported by appropriate documentation, such as lease, ledger, statement, or invoice. Individuals are eligible to receive assistance through this program **one time only**.

Applications must be submitted by a behavioral health treatment or service provider on behalf of an eligible individual. Applications submitted directly by individuals will not be accepted.

Approved payments will be made directly to landlords, property owners, or utility companies. Payments will not be issued directly to individuals. Approved payments are processed at the end of the month in which the application is approved.

To be considered for funding, the enclosed application worksheet and all required supporting documentation must be submitted. Applications will not be reviewed until all required documentation has been received. The referring service provider will be notified whether the application has been approved or denied.

This program is administered by Region 6 Behavioral Healthcare through funding provided by the National Opioid Settlement Agreement.

OUD Assistance Program Eligibility Requirements. Individuals must:

- Have an extremely low income or very low-income household income (see the income charts on page 5 of the application packet)
- Have Opioid Use Disorder (OUD) as their primary diagnosis documented through a substance use evaluation, completed within the past 12 months
- Be actively engaged with a treatment or service provider
- Be a Nebraska Resident and lawfully present in the United States

Eligible Assistance Requests May Include the Following:

- Security Deposit
- Rental Application Fees
- Rental Insurance
- Non-Recurring Rental Assistance, for up to two months
- Past-Due Rent (Rent Debt)
- Utility Deposits
- Past-Due Utility Payments (Utility Debt)
- Non-Recurring Utility Assistance, including electric, gas, propane, water, sewer, and garbage services, for up to two months

Documentation to be Included with Referral Application:

- Completed One-time Payment Application
- Copy of the individual's State ID or Driver's License
- Copy of the individual's Social Security card or proof of lawful presence (attestation of citizenship or qualified alien)
- Copy of the individual's current Substance Use Evaluation, dated within the past 12 months
- Documentation of income; pay stubs or benefit award letters. If the consumer is unemployed, please complete the attached Zero Income Questionnaire.
- Copy of the utility bill(s) (if requesting utility assistance)
- Copy of the lease, ledger, statement or invoice (if requesting assistance with past-due rent, a security deposit, or up to two months of rental assistance)
- Completed Release of Information/Authorization Form
- Completed W-9, New Vendor Information Form, and ACH Form from the landlord (if requesting rental or deposit assistance)

Referring organizations:

Applications on behalf of individuals can be received from opioid treatment programs, substance use residential facilities, substance use outpatient providers, halfway and ¾ way houses, homeless shelters, recovery homes, corrections or probation, and other similar service providers.

Equal Housing Opportunity - We do business in accordance with the Federal Fair Housing Law.

No person otherwise qualified for participation shall, based on race, color, sex, religion, national or ethnic origin, familial status, or disability, be excluded from participation in, denied the benefits of, or otherwise subjected to discrimination by Region 6 Behavioral Healthcare in the management and administration of this program.

Region 6 Behavioral Healthcare

OUD Rental and Utility Assistance One-time Payment Application

(Please Complete Entire Form)

This application form is for individuals residing in Region 6 (Cass, Dodge, Douglas, Sarpy, or Washington Counties) to apply for rental or utility assistance. Eligible applicants must be adults with an opioid use disorder diagnosis and meet very low-income requirements.

Region 6 Behavioral Healthcare manages this program. To be considered for assistance, this application and all required supporting documentation must be completed and submitted to:

Email, Mail, Fax, or Hand Deliver to:
Region 6 Behavioral Healthcare
Attn: April Ramsey
4715 S 132 Street
Omaha, NE 68137
Fax: 402-444-7722
Housing@regionsix.com

Questions regarding this form and/or status of an application may be directed to the address above or by contacting the Region 6 housing services by calling 402-444-7718.

Service Provider Submitting the Application

Agency Name: Agency Contact Person:

Phone: Email:

Applicant's Information

First Name: Middle Initial:

Last Name: Suffix:

Age: Date of Birth: SSN:

Gender: ☐Male ☐ Female

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black / African American

☐ Native Hawaiian / Other Pacific Islander ☐ White ☐ Hispanic ☐ Other

Disability: ☐ Yes ☐ No

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Insurance Status: ☐ Medicaid ☐ Medicare ☐ Tri-Care ☐ Private Insurance ☐ Self-Pay/No Insurance

Street Address: ☐ Homeless

City / State/ Zip:

County of Residence: ☐ Cass ☐ Dodge ☐ Douglas ☐ Sarpy ☐ Washington

Phone number:

Income Qualifications

Please identify all income sources of the individual. If the individual is unemployed, please fill out the Zero Income Questionnaire on page 7.

Income Category	Receiving	Denied	N/A	Amount
SSI				
SSDI				
Unemployment				
Employment/Wages				
VA Benefits				
General Assistance				
HHS- SNAP				
HHS-ADC				
Other:				
			Total Income	

Income Limits for Housing Assistance Eligibility based on Average Median Income (AMI) ***Cass, Douglas, Sarpy, and Washington counties***

	30% of AMI Extremely Low	**50% of AMI Very Low**	**80% of AMI Low**
1 person	$23,000	$38,350	$61,350
2 persons	$26,300	$43.800	$70,100
3 persons	$29,600	$49,300	$78,850
4 persons	$32,850	$54,750	$87,600
5 persons	$36,580	$59,150	$94,650
6 persons	$41,960	$63,550	$101,650
7 persons	$47,340	$67,900	$108,650
8 persons	$52,720	$72,300	$115,650

Dodge County

	30% of AMI Extremely Low	**50% of AMI Very Low**	**80% of AMI Low**
1 persons	$19,150	$31,950	$51,100
2 persons	$21,900	$36,500	$58,400
3 persons	$25,820	$41,050	$65,700
4 persons	$31,200	$45,600	$72,950
5 persons	$36,580	$49,250	$78,800
6 persons	$41,960	$52,900	$84,650
7 persons	$47,340	$56,550	$90,500
8 persons	$57,720	$60,200	$96,300

Number of People in Household:

☐ Extremely Low Income ☐ Very Low Income

Assistance Requested:

Eligible Categories	Description of Request	Amount Requested	Documents Included
Rental Application Fee			
Monthly Rent, for up to 2 months			
Security Deposit			
Rental Insurance			
Utility Deposits			
Non-recurring utility assistance, for up to 2 months (electric, gas, propane, water, sewer, and garbage service)			
Past-due rent (rent debt)			
Past-due utility payments (utility debt)			
	Total of Request: Not to Exceed $4,000		

Landlord/Property owner to be paid:

☐ W-9, New Vendor Form, and ACH Form Included in Supporting Documents

Utility company to be paid:

Agency/Provider Certification:

I certify that the information contained herein is true and correct to the best of my knowledge and belief. This information is being provided for the purpose of assisting the named consumer in applying for rental and/or utility assistance through Region 6 Behavioral Healthcare.

Signature of Service Provider: Date:

Printed Name:

Title:

Region 6 Behavioral Healthcare

Zero Income Questionnaire

Participant Name: _____

Lease Date: _____

Last Review Date: _____

Today's Date: _____

You have been shown to be at zero income on your submitted verifications since: _____

There are normal living expenses that continue even though you are not actively employed or receiving government financial assistance. We know that there is income that is not necessary to include as eligible income. This recertification ensures that eligible income has not been overlooked.

	Y	N
1. In the past month, have you had any income from any source?	☐	☐
2. Do you have any money in the bank somewhere?	☐	☐
3. Do you work at any odd jobs such as field work, babysitting, temp work etc.?	☐	☐
4. Do your parents, children, friends, or any other person outside your household give you help to meet your needs?	☐	☐

5. In the past month when you say you have had minimal or no money, how did you pay for the following and what is the avgerage monthly cost?
   a. Rent? _____
   b. Electricity?_____
   c. Telephone?_____
   d. Other Utility Bills?_____
   e. Food? _____
   f. Cleaning Supplies such as dish soap, laundry detergent, and other cleaning products?

      _____
   g. Paper goods such as toilet paper, paper towels, etc.?_____
   h. Personal hygiene items such as shampoo, deodorant, shaving cream, etc.?

      _____
   i. Do you have a washer and dryer? ☐ Y ☐ N
      If no, how do you pay for laundromat or other laundry expenses?_____

j. Do you smoke? ☐ Y ☐ N
If yes, how do you buy cigarettes or other tobacco products?
_____

k. Do you have cable television? ☐ Y ☐ N
If yes, how do you pay for this service? _____

l. How do you get around, i.e., transportation _____
If you own a car, how are expenses (gas, oil, insurance, etc.) paid?
_____

m. Do you have payments on charge cards or charge accounts? ☐ Y ☐ N
If yes, how are they paid? _____

n. Do you have medical expenses ☐ Y ☐ N
If yes, please describe: _____

What are your plans for obtaining income? Have you applied for employment or disability, when, and status?

_____
_____
_____
_____

I acknowledge that I must participate in ongoing behavioral healthcare services and ongoing behavioral health case management at least once a month. I must also obtain income through employment or Social Security within six (6) months of entering the program. Failure to comply with any of these requirements may result in the termination of my rental assistance. PLEASE MAKE SURE ALL QUESTIONS ARE COMPLETED BEFORE SUBMITTING THIS FORM.

_____	_____
Signature of Interviewer	Signature of Participant
_____	_____
Printed Name of Interviewer	Printed Name of Participant
_____	_____
Date	Date

Region 6 Behavioral Healthcare
4715 South 132nd Street
Omaha, NE 68137
Phone: (402) 444-6573
FAX: (402) 444-7722

Authorization for Disclosure of Information

Name of Individual for Whom You Are Requesting/Providing Authorization:

All information requested is covered by federal regulation 45 C.F.R. the Health Insurance Portability and Accountability Act (HIPAA) Parts 160 and 164. Drug and alcohol information may be covered by federal regulation 42 C.F.R. Part 2.

I authorize the exchange of information *(to receive and obtain)* between Region 6 Behavioral Healthcare
☐ Professional Partners ☑ Other Region 6 Program ___Housing___and the person, provider, facility, or position type listed below.

Name of Person, Provider, Facility, or Position Type

Address (If Known)

Phone Number FAX Number

City, State, Zip (If Known)

☐ Address Unknown

Email

You have the right to choose what information is shared. Select the information to be exchanged by marking below.

☐ I authorize the exchange of all information listed below, including information which may contain HIV status and Alcohol/Drug records.

Select the appropriate boxes below if you would like only certain types of information exchanged:

☐	Assessment Information	☐	Individual Education Plan
☐	Aftercare/Discharge Plan	☐	Medical History
☐	Current Medications	☐	Progress Reports/ Summary of Treatment
☐	Discharge Summary	☐	Psychiatric History and Diagnosis
☐	**Drug/Alcohol Information/Evaluation**	☐	Psychological Testing Information
☐	Educational Information	☐	Treatment/Service Plan
☐	Financial Resources & Eligibility	☐	Other:
☐	**HIV Information**		

If no type of information selected, all information may be exchanged except HIV related information and Drug/Alcohol information which requires your specific authorization.

This use and disclosure is for the following purpose: _____

If no purpose is described and the individual initiated the authorization, information will be shared at the request of the individual for purposes of care, treatment, and service delivery.

If requested records are protected by 42 C.F. R. Part 2, records protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, I understand that such records cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I can change my mind and this Authorization may be revoked at any time in writing. I understand that any uses or disclosures already made with my permission cannot be taken back. If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims. I understand this authorization is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by state or federal confidentiality laws.

Unless otherwise revoked, this Authorization will expire on the following date, event (such as discharge), or condition: _____. If I fail to specify an expiration date, event or condition, this Authorization will expire twelve (12) months from the date below. I acknowledge that I have received a copy of this Authorization for Disclosure of Information form.

Individual's Signature | Date | Personal Representative Signature | Date

Witness Signature | Date | Authority of Personal Representative

Region 6 Behavioral Healthcare
New Vendor Information Sheet

Date: _____

Vendor Name: _____

DBA (if applicable): _____

Address: _____

City/State/Zip: _____

Mailing Address *(if different from above)*: _____

Mailing City/State/Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Title: _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

If entity is an LLC, please include tax classification

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Region 6 Behavioral Healthcare
Vendor ACH Information Form

Region 6 Behavioral Healthcare offers ACH as a method of payment which, would allow funds to be directly deposited to your bank account within one day of payment processing. To initiate ACH, please complete the information below and return the form to:

Accounting@regionsix.com or fax to 4**02-444-7722.**

Company Name: _____

Bank Name: _____

Account Number: _____

ACH Routing Number/ABA: _____

☐ Checking ☐ Savings

_____ _____

Company Representative Date