Mosaic Community Services and Behavioral Health Systems Baltimore
Co-Occurring and Supported Housing
Grant Application

1925 GREENSPRING DR. TIMONIUM, MD 21093
410-747-4492 x1944 FAX 443-612-1456

Date: _____________

Consumers Name: ________________________________ Date of Birth: _________________

Address______________________________ Referral Source: _____________________

____________________________________ Contact Number: _____________________

Phone_______________________________

The Grant is intended to help facilitate movement from a state hospital or RRP program to a community housing setting. How will this individual moving out open a bed within your program for a client coming out of the State Hospital? Have you worked with BHSB to identify an individual within the state hospital system who will fill this vacancy? **Yes / No (circle one).**

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Current Income (monthly amount): Amount: _________________ Source: ________________

Amount: _________________ Source: ________________

Additional Housing Needs for start-up of living space? ____

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Expenses for which Consumer needs assistance

Items	**Total Amount**	**Amount of Assistance Needed**
Security Deposit:		
Monthly Rent:		
Other:		
Other:		

Consumers plan for permanent subsidy- Consumer will need to show what their plan is to find permanent subsidy (Section 8 etc.)?

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What Peer Support Services will be required to assist with this transition: ____________________________

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Consumers Signature: _______________________________________ Date: ___________

Referral Source Signature: ____________________________________ Date: ___________