

**Division of Mental Health Permanent Supportive Housing Bridge Subsidy Initiative**  
**Signature Page**

**SIGNATURES**

I understand and affirm that if the applicant is approved for a Bridge Subsidy and is currently residing in a DMH contracted supervised or supported residential treatment setting (including MH-CILA) he or she will move out of this setting to execute the Bridge Subsidy.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Care Manager

\_\_\_\_\_  
Date

I authorize the Division of Mental Health and its contracted entities to utilize the information contained in this application to determine my eligibility for the DMH Bridge Subsidy Initiative and to contact my care manager with questions or information regarding this application. I agree to complete additional forms/documentation that may be required to finalize my application. I certify that all information contained in this form is true to the best of my knowledge.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

I certify that I have reviewed all information contained in this referral with the Applicant and that all information is true to the best of my knowledge.

\_\_\_\_\_  
Signature of Care Manager

\_\_\_\_\_  
Date

Thank you for completing the Application for the Division of Mental Health Permanent Supportive Housing Bridge Subsidy Initiative. The information you have provided will be reviewed and a response will be emailed to you within 10 business days of the receipt of this Application.