



**MENTAL HEALTH
AND RECOVERY
SERVICES BOARD**
of Stark County

ENRICHING LIVES THROUGH WELLNESS AND RECOVERY

EMC Application

Instructions: Complete sections I-III as directed below and fax or mail to MHR SB
Program Coordinator, 800 Market Avenue North, Suite 1150, Canton, Ohio 44702, (330) 455-7424

I. APPLICANT INFORMATION

Name	Social Security Number	Date of Birth
Case Manager	Agency	Phone Number

II. ACF INFORMATION (See current Board Approved ACF List for eligible facilities)

ACF Name	Address	
Resident Room Capacity <input type="checkbox"/> Single Occupancy <input type="checkbox"/> Double Occupancy <input type="checkbox"/> Other _____	Move-In Date	Monthly Rent \$

III. FINANCIAL INFORMATION (Attachments required)

Monthly Income \$	Income Source (<u>Must</u> attach verification of income/application of benefits)	Payee
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Notes

I certify that all answers in this application are true and complete to the best of my knowledge. I understand that ODH ACF Rule 3701-20-18(B)(1), in conjunction with MHR SB standards, require ACFs to have for each resident a Residential Agreement, Plan of Care, Health Assessment, TB test, & Capability for Self Medication Administration. I agree to ensure that these documents are completed with the required time limits as listed in the MHR SB EMC Directions.

Case Manager Signature _____ Date _____ Resident Signature _____ Date _____

Office Use Only

IV. MHR SB VERIFICATION & AUTHORIZATION

Date Received	<input type="checkbox"/> Stark County Resident <input type="checkbox"/> Enrolled in Service	ACF <input type="checkbox"/> I \$650 Type <input type="checkbox"/> II \$725	Tenant Rent \$	Authorized EMC \$
Notes				
Application	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	MHR SB Representative _____ Date _____		

V. ICAN VERIFICATION & AUTHORIZATION

<input type="checkbox"/>	Plan of Care (Written in collaboration with resident, agency & ACF)	Expiration Date
<input type="checkbox"/>	Health Assessment, including TB test or chest x-ray (If applicable)	Expiration Date
<input type="checkbox"/>	Residential Agreement	Effective Date
<input type="checkbox"/>	Verification of income or application for benefits	
Verified EMC Amount \$	ICAN Representative _____ Date _____	