Date Received:_____

COUNTY OF BERGEN
DEPARTMENT OF HEALTH SERVICES
One Bergen County Plaza, 4th Floor, Hackensack, New Jersey 07601
(201) 634-2600 • FAX (201) 336-6086
www.bergenhealth.org
healthdept@co.bergen.nj.us

James J. Tedesco III
County Executive

Hansel F. Asmar
Director/Health Officer

Bergen County Resolution No. 704-17 ***Date of Adoption: July 26, 2017***

The Bergen County Board of Chosen Freeholders has authorized $50,000.00 in funds to promote mental health awareness, wellness and linkages to resources. The Bergen County Department of Health Services has been directed to utilize the funds specifically to:

- *Provide direct assistance to consumers of community mental health services to promote his/her own individual wellness and recovery wherein his/her specific needs cannot be addressed by other sources;*
- *Address and remediate issues created by hoarding behaviors;*
- *Promote the Stigma-Free Initiative throughout the county to enhance a culture of caring in each of our communities so residents who are living with the disease of mental illness feel supported, rather than ashamed, in seeking treatment so their recovery can begin;*
- *Support our first responders, schools and communities during and after tragic events.*

APPLICATION FOR MENTAL HEALTH AWARENESS, WELLNESS AND LINKAGES FUNDS

All applications will be reviewed by a subcommittee of the Bergen County Mental Health Board in partnership with the Mental Health Administrator. Decisions to fund all, a portion or none of the items requested on this form will rest with the Board' s subcommittee. Submission of this form does not guarantee funding. Applications that are incomplete will not be processed. Deadline for submission is December 15, 2017. Applications will be considered in order of date received.

Name: _____

Address: _____

Telephone: _____ **E-Mail:**_____

I certify that I live with the disease of mental illness and am currently receiving treatment for my disease. I am requesting these dollars to help promote my wellness and recovery. I am requesting these dollars as I am unable to find any other way to pay for the need I detailed on the reverse side of this form.

Signature: _____ **Date:** _____

Please have the person who helps you work towards, or maintain recovery, sign below to verify that you are actively leading and participating in your wellness and recovery.

Name of Treatment/Support Provider :_____

Telephone: _____ E-Mail:_____

Agency/Practice Name: _____

Signature:_____

Your signature verifies that the person requesting your signature is actively engaged in your service to promote his/her wellness and recovery.

Complete the reverse side of this form.

Description of Need: _____

_____

_____

_____

What other sources have been explored to cover the cost of this need?
[Check all that apply.]

____ Public Assistance ____ Local Social Services Department ___ County program

____ Clinic [*circle mental health; dental; federally qualified health care center; other: _____]*

____ Charitable Club *[Rotary; Lions; Knights of Columbus; Elks, etc.]* ____ Food/clothing bank

____ Community agency *[United Way, Greater Community Action Program, etc.]*

_____ Insurance ____ Other: specify - _____

What is the reason the source[s] listed above could not cover the cost of your need? Attach copy of *each* written denial letter.

_____

_____

_____

Amount of Funds Requested: $_____ [**attach** written invoice, billing statement, cost estimate, etc.]
Payment will be forwarded directly to vendor / provider of service. Funds will not be allocated to individuals.

A copy of this form will be mailed directly to you, at the address you listed on the front of this form, so you will know if your request was approved, in what amount and when the payment was forwarded [see box below].

RETURN FORMS to: Michele Hart-Loughlin, Bergen County Department of Health Services - Division of Mental Health, One Bergen County Plaza, 4th Floor, Hackensack , NJ 07601

Phone: 201-634-2745 **E-Mail: MHARTLO@CO.BERGEN.NJ.US**
Fax: 201-336-6086 *[If you opt to fax, please call first as the fax is shared by many].*

Reviewed by: _____

Date: _____ **Amount Approved: $**_____

Check #:_____ **Mailed Date:** _____ **Destination Name:** _____

Destination Address: _____