Bridges Program
CERTIFICATION AND AUTHORIZATION
For Payment of Deposits and Rent During Crisis

Participant Name _____

	Amount	Name and Address Of Person/Agency to be Paid
Rent During Medical or Psychiatric Crisis	$_____	_____
		_____
		_____

I certify that the Participant will be absent from the assisted unit due to a medical or psychiatric crisis and that there is a high likelihood that the Participant will return to the unit within the next three months. I will keep the Housing Agency informed of the status of the Participant.

_____ _____
Signature of Case Manager/Housing Support Provider Date

Security Deposit	$_____	_____
Utility Deposit	$_____	_____
		_____

I certify that the Participant does not have the resources to pay the above deposit and that there are no other sources of funds available to this Participant to cover these costs.

_____ _____
Signature of Case Manager/Housing Support Provider Date

_____ _____
Signature of County/Agency Staff giving approval for payment (if necessary) Date