

STATE OF NEW HAMPSHIRE



OFFICE OF LEGISLATIVE SERVICES  
ADMINISTRATIVE RULES  
STATE HOUSE ANNEX  
25 CAPITOL STREET, ROOM 234  
CONCORD, NH 03301

## Interim Rulemaking Notice Form and Cover Sheet

**Proposed Interim Rule Number:** 2026-19

**Rule Number:** He-M 406

- Agency:** Department of Health and Human Services  
  
**Agency Address:** Department of Health and Human Services  
Bureau of Mental Health Services  
105 Pleasant Street, Main Bldg.  
Concord, NH 03301
- RSA Authority:** RSA 135-C:5, I and RSA 135-C:61, III
- Federal Authority:**
- Action(s):** Readopt
- Filing Date:** August 19, 2026
- Short Title:** Housing Bridge Subsidy Program
- Contact person for copies and questions including requests to accommodate persons with disabilities:**

|                                                                                                                                           |                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| <b>Name:</b> Allyson Raadmae                                                                                                              | <b>Title:</b> Administrator- Administrative Rules Unit |
| <b>Address:</b><br>Dept. of Health and Human Services<br>Administrative Rules Unit<br>129 Pleasant Street, 2nd Floor<br>Concord, NH 03301 | <b>Phone Number:</b> (603) 271-9604                    |
|                                                                                                                                           | <b>FAX Number:</b> (603) 271-5590                      |
|                                                                                                                                           | <b>Email:</b> Allyson.E.Raadmae@dhhs.nh.gov            |

8. **Summary explaining the effect of the rule and, if the rules are being proposed to implement a state statute for the first time, identification of the statute and/or relevant session law being implemented pursuant to RSA 541-A:19, I(a):**

He-M 406 describes the eligibility criteria, the application process, the services offered, the wait list, and the appeal procedures for the housing bridge subsidy program which provides supported housing to people who have serious mental illness. The purpose of supported housing is to reduce institutionalization by combining mental health outreach services with a subsidy to help pay rent. The rental subsidy terminates when the individual receives a Section 8 Housing Choice Voucher. Accordingly, in order for a person to be eligible for the housing bridge subsidy program, the person must apply for the Section 8 Housing Choice Voucher. He-M 406 is scheduled to expire on September 27, 2026.

The Department of Health and Human Services (Department) is proposing to readopt He-M 406 as an interim rule pursuant to RSA 541-A:19, I(d) to continue the rules which would otherwise expire prior to the completion of the readoption of the rules by the agency.

There are no revisions being made to this rule and this proposal does not implement a state statute for the first time.

9. **Listing of people, enterprises, and government agencies affected by the rule:**

He-M 406 affects individuals who are eligible for mental health services who are on a wait list or applying for the Section 8 Housing Choice Voucher Program.

10. **Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:**

| <b>RULE</b> | <b>STATE OR FEDERAL STATUTES THE RULE IMPLEMENTS</b> |
|-------------|------------------------------------------------------|
| He-M 406    | RSA 135-C:5, I                                       |

11. **Agency form(s) as required by RSA 541-A:19, IV-a which this rule incorporates by reference or whose requirements are set forth in the rule pursuant to RSA 541-A:19-b.**

☒ **Yes**

12. **Summary of the effect upon the state if the rule were not adopted:**

If this rule were not adopted, the Department would be unable to continue the Housing Bridge Subsidy Program and individuals who utilize this program would be unable to have these services provided to them which could result in the loss of housing.

13. **Proposed date of review by the Joint Legislative Committee on Administrative Rules:**

September 17, 2026

**14. The fiscal impact statement prepared by the Legislative Budget Assistant, if applicable:**

Not applicable.

**\*\*PLEASE SIGN THE FOLLOWING:**

**I, the adopting authority,\* hereby certify that the attached is an accurate statement explaining why an interim rule is necessary.**

**Date:** 2026-08-19 **Name:** Lori A. Weaver **Title:** Commissioner

*\*('Adopting authority' is the official empowered by statute to adopt the rule, or a member of the group of individuals empowered by statute to adopt the rule.)*

**Files Uploaded to Server:**

1. INT Form 1 (Housing Bridge Application) He-M 406.pdf
2. INT Form 2 (Housing Bridge Intake Form) He-M 406.pdf
3. INT NTC-CVRSHT He-M 406.pdf
4. INT Rule Text He-M 406.docx

This list shows only files that have already been uploaded.

\* denotes files uploaded by Rules

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**I, the adopting authority,\* hereby certify that the attached is an accurate statement explaining why an interim rule is necessary.**

**Date:** 8/12/2026

**Signature:** Lori Weaver

**Name:** Lori A. Weaver

**Title:** Commissioner

**Date:** 8/12/2026

**Countersigned by:** Patricia Tilley

**Name:** Patricia Tilley

**Title:** Associate Commissioner

*\*('Adopting authority' is the official empowered by statute to adopt the rule, or a member of the group of individuals empowered by statute to adopt the rule.)*

**STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HOUSING BRIDGE SUBSIDY PROGRAM APPLICATION**

**State Office Park South  
105 Pleasant Street  
Concord, NH 03301**

**INSTRUCTIONS:**

- Please complete this form carefully.
- Incomplete applications will not be accepted.
- Please print clearly and fax completed applications to 603.271.5040
- The applicant must apply to New Hampshire Housing Finance Authority for a Section 8 Housing Choice Voucher before submitting this referral.

**Application Submitted by:**

- |                                                          |                                                                    |
|----------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Community Mental Health Program |                                                                    |
| <input type="checkbox"/> New Hampshire Hospital          | <input type="checkbox"/> Designated Receiving Facility (DRF)       |
| <input type="checkbox"/> Glenclyff Home                  | <input type="checkbox"/> The Transitional Housing Services Program |

**Contact Name:**\_\_\_\_\_

**Contact Phone Number:**\_\_\_\_\_

**APPLICANT INFORMATION**

Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Zip Code of last permanent address: \_\_\_\_\_ Last 4 Digits of SSN: \_\_\_\_\_

Gender: \_\_\_\_\_

Are you a US citizen? Yes No If no, what is your citizenship status? \_\_\_\_\_

Do you need accessible housing? Yes No

**Housing Status:**

☐ Ready for discharge from New Hampshire Hospital, Glenclyff Home or a Designated Receiving Facility, but lack housing options in the community.

- ☐ Proposed discharge date: \_\_\_\_\_
- ☐ Will there be a conditional discharge? \_\_\_\_\_

☐ Ready for discharge from the Transitional Housing Program operated on the grounds of New Hampshire Hospital, but lack housing options in the community.

☐ Currently homeless and on an Assertive Community Treatment Team (ACT).

If currently homeless, what is homeless status?

- ☐ Shelter
- ☐ Street
- ☐ Other

Which Community Mental Health Program has the applicant found eligible through:

\_\_\_\_\_

Is the applicant currently on an ACT team, or being referred to one? \_\_\_\_\_

If not connected with a CMHC, what is the scheduled intake date? \_\_\_\_\_

### LIVING SITUATIONS

Do you currently own your own home? Yes No      If yes, are you facing foreclosure? Yes No  
Do you have a car? Yes No

Address prior to homelessness: \_\_\_\_\_

Reason for homelessness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you living in Subsidized Housing? Yes No

Have you ever applied for Section 8 or other Subsidized Housing? Yes No

If yes, please list date and place application(s) were made.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever held a Section 8 voucher? If yes, please describe- including reasons why voucher was lost.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been evicted from housing? If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list the name, phone number, and fax number of your current landlord:

\_\_\_\_\_

#### Household Members:

| Name: | DOB: | Last 4 SSN | Relationship | Gender |
|-------|------|------------|--------------|--------|
|       |      |            |              |        |
|       |      |            |              |        |
|       |      |            |              |        |
|       |      |            |              |        |

### **FINANCIAL INFORMATION**

#### **Household Monthly Income Cash:**

Earned Income \$ \_\_\_\_\_  
Unemployment Insurance \$ \_\_\_\_\_  
SSI \$ \_\_\_\_\_  
SSDI \$ \_\_\_\_\_  
Veteran's Disability Payment \$ \_\_\_\_\_  
Private Disability Insurance \$ \_\_\_\_\_  
Worker's Compensation \$ \_\_\_\_\_  
TANF \$ \_\_\_\_\_  
APTD \$ \_\_\_\_\_  
General Assistance \$ \_\_\_\_\_  
Retirement Social Security \$ \_\_\_\_\_  
Veteran's Pension \$ \_\_\_\_\_  
Pension from Former Job \$ \_\_\_\_\_  
Child Support \$ \_\_\_\_\_  
Alimony/Spousal Support \$ \_\_\_\_\_  
Other: \$ \_\_\_\_\_

#### **Household Non-Cash Benefits:**

Food Stamps \$ \_\_\_\_\_  
MEDICAID \$ \_\_\_\_\_  
MEDICARE \$ \_\_\_\_\_  
SCHIP \$ \_\_\_\_\_  
Supp Nutrition for WIC \$ \_\_\_\_\_  
VA Medical Services \$ \_\_\_\_\_  
TANF Child Care \$ \_\_\_\_\_  
TANF Transportation \$ \_\_\_\_\_  
Other TANF-funded \$ \_\_\_\_\_  
Section 8/ Public Housing \$ \_\_\_\_\_  
Temporary Rental Assistance \$ \_\_\_\_\_  
Other: \_\_\_\_\_ \$ \_\_\_\_\_

**Total Monthly Income:** \$ \_\_\_\_\_

#### **Monthly Household Expenses:**

| <b>Expense</b> | <b>Amount</b> | <b>Expense</b> | <b>Amount</b> | <b>Expense</b> | <b>Amount</b> |
|----------------|---------------|----------------|---------------|----------------|---------------|
| Rent           | \$ _____      | Heat           | \$ _____      | Child Care     | \$ _____      |
| Telephone      | \$ _____      | Food           | \$ _____      | Other:         | \$ _____      |
| Electricity    | \$ _____      | Transportation | \$ _____      |                |               |
| <b>Total:</b>  | \$ _____      |                |               |                |               |

### **EMERGENCY CONTACT INFORMATION**

**Emergency Contact Name:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Relation to Applicant:** \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| Are any members of your household subject to the registration requirement under <b>RSA 651-B "Registration of Criminal Offenders"</b> ?                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes      No |
| Within the past 7 years, have you or anyone in your household ever been convicted of the illegal manufacture, sale, or distribution of a controlled drug, or the possession of a controlled drug with the intent to manufacture, sell, or distribute, that has not been annulled ?                                                                                                                                                                                                                                                                                   | Yes      No |
| Within the past 15 years, have you or anyone in your household ever been convicted a violent criminal offence, that has not been annulled? <b>Violent criminal offence means any conviction that has as one of its elements the use, attempted use, or threatened use of physical force substantial enough to cause, or be reasonably likely to cause, serious bodily injury or property damage including but not limited to murder, manslaughter, assault, rape, robbery, burglary, arson, and kidnapping. This term does not include simple assault by itself.</b> | Yes      No |
| Have you or anyone in your household ever committed any fraud in a federally assisted housing program or been requested to repay money for knowingly misrepresenting information for such housing programs?                                                                                                                                                                                                                                                                                                                                                          | Yes      No |

**Certification:** I certify, under penalty of unsworn falsification, that all of the information in this application is true and complete to the best of my knowledge and belief. False information will result in denial of the application or dismissal from this program.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

**STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HOUSING BRIDGE SUBSIDY INTAKE FORM**

**State Office Park South  
105 Pleasant Street  
Concord, NH 03301**

**INSTRUCTIONS:**

- Please complete this form carefully.
- Please print clearly and fax completed intake form to 603.271.5040 or mailed to the address above.
- If you have questions please call 603.271.0845

**APPLICANT INFORMATION**

**Date:** \_\_\_\_\_ **Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Mailing Address:** \_\_\_\_\_

**Current Living Situation:** \_\_\_\_\_

**Are you connected to a Community Mental Health Center? If yes, which one:**

\_\_\_\_\_

**CMHC Contact Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_