Every Penny Counts Emergency Assistance
PO Box 582943
Minneapolis, MN 55458-2943
(612) 331-7733 Metro Area
(800) 565-9028 Greater MN
(612) 341-3804 Fax

EPC Client # ___________
PE Client # ___________
(for office use only)
4/1/08 – 3/31/09
Prior forms no longer valid

See attached guidelines and eligibility criteria form

____
Last name First name Middle initial

____
Address City State Zip

_____ HIV positive - Year of dx: __________ AND/OR _____ AIDS diagnosis – Year of dx: ___________

Phone (   )_____________________________ Can we leave a message? ____ yes ____no

OK to receive mail from Every Penny Counts? ___yes ___ no, From MN AIDS Project? ____ yes ____no

Case manager/service providers name _________________________ Phone (   ) _________________

Physician name ____ Phone (   ) _________________

Have you seen a medical provider in the last 6 months: ___yes Date:_____________ no____ unknown____

If you would like a referral to a medical provider, contact the MAP AIDSLine at 612-373-2437 or 1-800-248-2437.

Date of birth ______/______/______ Age _______ Social Security #: _________ - ______ - ___________

Expected **Annual** family gross income (wages, SSDI, GA, etc): $ ___________________

Number of people legally dependent on this income (including yourself) _______________

You must provide documentation/proof of income. You have 2 options. Place a check next to the option you have chosen:

____**Option 1,** Complete this section:
Do you or anyone in your family (married spouse, dependent children) receive income from a source listed below? If yes, please place a check in front of all income sources.

___Supplemental Security Income (SSI)
___Social Security
___Alimony
___Employment
___Child support
___Pension
___W2
___Unemployment insurance
___Rental income
___Veteran's benefits
___Other: ______________________________
___Public assistance payments
___Worker's compensation
___Disability payments

Attach Documents of proof of income when submitting application, ie: Social security check, employment pay stub, SSI letter, MFIP letter, bank statement, etc. **We cannot process your application without documentation of your income.**

____**Option 2:**
If you are on Medical Assistance (MA), you may send a copy of your medical card with your application for income verification documentation.

____**No Income:**
I certify that I'm not able to provide proof of income for I have **no income**. (please initial) _________

Please be sure to complete both sides of this application!

The Minnesota Department of Health (MDH) and Hennepin County require some personal information be collected and reported periodically for the following purposes: to identify the services that people with HIV/AIDS need and use, to identify barriers to those service and to evaluate future funding needs, to determine you eligibility for services and to verify to funding sources that this service is being provided. You have the right to refuse to share information about yourself however, in some cases MAP will be unable to provide some types of service to you unless we have this information. Your name or any other identifying information is not released to the Minnesota Department of Health or Hennepin County as a condition of funding.
Please initial that you have read and understand the paragraph above: ________________

Current Physical Gender
______ Male
______ Female

Transgender:
______ Male to Female
______ Female to Male

Ethnicity
(select one)
_____ Hispanic/Latino
_____ Not Hispanic/Latino
_____ Refused
_____ Unknown

What do you consider to be your race
(select all that apply)
______ American Indian
______ Caucasian/White
______ African American/Black
______ African born
______ Pacific Islander
______ Hispanic/Latino
______ Asian
______ Other ______________________
______ Refused
______ Unknown

Country of Birth:__________________________

County of Residence __________________________

Living Situation (select one)
______ Homeless
______ Permanent housing (ie: rental unit, own home, etc.)
______ Non-Permanent housing (ie: transitional or temporary)
______ Institution (ie: supervised group or halfway home)
______ Other ______________________
______ Refused
______ Unknown

How many children live with you more than 20 hours per week?___________

Medical Insurance
(select one)
______ Private
______ Medicare
______ Medicaid (ie: MA)
______ Other Public (ie: VA, GAMC)
______ No Insurance
______ Other ____________________
______ Refused
______ Unknown

Exposure
(mark ALL that apply)
______ Male/male sex
______ Male/female sex
______ Injecting drug use
______ Blood recipient
______ Hemophilia
______ Perinatal transmission
______ Occupational exposure
______ Other: _____________
______ Refused
_____ Unknown

I acknowledge that the information provided in this application is true and I authorize "Every Penny Counts Emergency Assistance" to verify the accuracy of the information as necessary.

____
Client Signature   Date

Completion of this application and my signature above constitute a consent to receive services & acknowledges that I have received a copy of the Client Bill of Rights from Every Penny Counts Emergency Assistance.