

## MAP Transportation Program Application

Please complete all information requested on this form. Incomplete applications may not be processed.

First Name	Middle Initial	Last Name
Address	County	
	<input type="checkbox"/> YES	<input type="checkbox"/> NO
City	State	Zip (Required)
OK to Send Mail (envelopes do NOT say "MAP")		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Phone (s)	OK to leave message	Birth date (MM/DD/YY)

Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone #: \_\_\_\_\_

Expected Annual household gross income (wages, SSDI, GA, etc): \$ \_\_\_\_\_

Number of people legally dependent on this income (including yourself): \_\_\_\_\_

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

Option 1

Attach documents showing proof of income such as a copy of: your most recent pay stub (within the last 30 days), last years tax return, an affidavit or letter of support, a benefit statement such as a Social Security award letter, MFIP award letter, a bank statement, etc.

**We cannot provide services to you without documentation of your income.**

Option 2:

If you are on Medical Assistance (MA), you may send a copy of your medical card in with this form for income verification documentation.

Option 3:

I certify that I'm not able to provide proof of income for I have no income (please initial): \_\_\_\_\_

Living Situation:  Stable/Permanent  Temporary  
 Unstable  Unknown

Race (Select one or more):

White  American Indian/Alaska Native  Asian  
 African American/Black  Native Hawaiian/Pacific Islander  Unknown

**[Be sure to complete both sides of this application]**

**Ethnicity (Select one):**

- Hispanic/Latino                       Not Hispanic/Latino                       Unknown

**Gender (Select one):**

- Male     Female     Transgender male to female     Transgender female to male

**HIV/AIDS Status (Select one):**

- HIV positive, not AIDS  
 HIV positive, AIDS Status Unknown  
 Have AIDS diagnosis  
 HIV Diagnosis Pending – Pediatrics Only

Date of HIV Diagnosis \_\_\_\_\_ Month/Day/Year

Check box below if date is estimated

Estimated date of HIV diagnosis

Date of AIDS Diagnosis \_\_\_\_\_ Month/Day/Year

Estimated date of AIDS diagnosis

**Have you seen on HIV medical provider in the last 6 months?:**

- Yes, Month/Day/Year of appointment: \_\_\_\_\_  No  Unknown

If "No" and you would like a referral to a doctor, contact the AIDSLine at (612) 373-2437.

**Exposure Category:**

Select one or more

- Male who has sex with males                       Hemophilia  
 Injection Drug Use     Blood Recipient                       Other  
 Heterosexual Sex     Perinatal Transmission                       Unknown

**Health Insurance:**

Select one or more

- Private                       Other (includes MCHA)  
 Medicare # \_\_\_\_\_  
 Medicaid (MA) # \_\_\_\_\_  Unknown  
 Other Public  
 No Insurance

**Country of Birth:**  USA  Other: Specify \_\_\_\_\_  Refused  Unknown

**Did you move to Minnesota within the last six months:**  Yes  No

By completing and signing this application I acknowledge that I have read and understand the program guidelines and consent to receive services from MAP. I also acknowledge I have received of a copy of the MAP Client Bill of Rights. I acknowledge that the information provided in this application is true and I authorize MAP to verify the accuracy of the information as necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Return to: MAP  
1400 Park Ave  
Minneapolis, MN 55404