

# MAP Transportation Program Application

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

First Name		Middle	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")	
Phone (s)			Birthdate (MM/DD/YY)	

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

**Referred by:** \_\_\_\_\_ **Phone # (of referral):** \_\_\_\_\_

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

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

**Number of children who live with you more than 20 hours per week:** \_\_\_\_\_

**You must provide documentation of 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.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Unemployment insurance | <input type="checkbox"/> Public assistance payments |
| <input type="checkbox"/> Social Security                    | <input type="checkbox"/> Alimony                | <input type="checkbox"/> Rental income              |
| <input type="checkbox"/> Employment                         | <input type="checkbox"/> Child support          | <input type="checkbox"/> Veteran's benefits         |
| <input type="checkbox"/> Pensions                           | <input type="checkbox"/> Other: _____           | <input type="checkbox"/> Disability payments        |

Attach Documents of proof of income when submitting application, 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 transportation 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.

**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!**

**Living Situation:**

- Homeless
- Institution
- Other

- Non-Permanent Housing
- Permanent Housing

- Refused
- Unknown

**Race:**

- White
- African American/Black
- Hispanic/Latino

- American Indian/Alaska Native
- Pacific Islander
- Asian

- Unknown
- Refused
- Other

**Ethnicity:**

Hispanic/Latino

Not Hispanic/Latino

Unknown

Refused

**Gender:**

Male

Female

Transgender male to female

Transgender female to male

**HIV/AIDS Status:**

Client has HIV Infection \_\_\_\_\_ Year Diagnosed

Client has AIDS diagnosis \_\_\_\_\_ Year Diagnosed

Client does not have HIV/AIDS

HIV Diagnosis Pending – Pediatrics Only

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

Yes, Month & Year: \_\_\_\_\_

No

Refused

Unknown

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

**Exposure Category:**

M/M Sex

Hemophilia

Occupational Exposure

M/F Sex

Blood Recipient

Other \_\_\_\_\_

Injection Drug Use

Perinatal Transmission

Unknown

Refused

**Health Insurance:**

Private

No Insurance

Medicare # \_\_\_\_\_

Pending

Medicaid # \_\_\_\_\_

Unknown

MCHA

Refused

Other Public

**Country of Birth:**

USA

Other, Specify \_\_\_\_\_

Refused

Unknown

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Completing and signing this application constitutes consent to receive transportation services from MAP Transportation services.

Return to: MAP  
Transportation Program  
1400 Park Ave  
Minneapolis, MN 55404