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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Apt #</th>
<th>County</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
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</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip (Required)</th>
<th>OK to Send Mail (envelopes do NOT say &quot;MAP&quot;)</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Phone (s) include area code</th>
<th>Birthdate (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Case Manager/Social Worker: ___________________________ Phone #: ___________________________
I authorize my Case Manager/Social Worker/HIV provider to exchange information with EPCEA staff regarding financial assistance: (initial)

Physician name: ___________________________ 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 for all family members who have income.
Income verification is needed every 6 months. Place a check next to the option you have chosen below:

1. **Option 1**
   - Attach documents showing proof of income such as a copy of: your most recent pay stub (within the last 30 days), a 2016 tax return, certification of zero income form or affidavit, a benefit statement such as a 2017 Social Security award letter, MFIP award letter, a bank statement showing deposit of income, etc.
   - **We cannot provide services to you without documentation of your income.**

2. **Option 2:**
   - If you are on Medical Assistance (MA, IM, QI) you may send a copy of your Medical Assistance card indicating that you are on MA or MN-ITS print out as income verification documentation. If you have a spend down or any unusual situation with MA, we may need to collect additional income verification. MN-ITS showing MinnesotaCare also works for income.
   - Please Note: enrollment in Program HH, or a copy of your MN Health Care Programs card do not qualify as income verification for EPC.

3. **Option 3:**
   - Zero Income and I have completed and attached the Certification of Zero Income.

   Living Situation: □ Stable/Permanent □ Temporary □ Unstable

   You must provide proof of Minnesota residency. Proof of residency is needed every 6 months. Place a check next to the option you have chosen below. Use attached Residency Verification form if homeless, do not have a fixed address or have a fixed address but do not have a driver’s license, state ID, utility bill, lease agreement, MN-ITS printout.

   □ Copy of driver’s license / MN State I.D. □ Current Lease agreement □ MN-ITS printout
   □ Current Utility Bill □ Read and sign MAP Residency Verification Form

*Be sure to complete both sides/pages of this application*
Race (Select one or more):
- White
- African American/Black
- American Indian
- Native Hawaiian
- Alaska Native
- Pacific Islander
- Asian

Ethnicity (Select one):
- Hispanic/Latino
- Not Hispanic/Latino

Gender Assigned at Birth (Select one):
- Male
- Female

Current Gender Identity (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

Date of AIDS Diagnosis __________________________ Month/Day/Year

When was your last visit to your HIV doctor/lab work?: (Doctor visit information is needed every 6 months)

Month/Day/Year of appointment: __________________________

If you’re not in medical care please contact the AIDSLine at (612) 373-2437 for a physician referral.

Exposure Category:
- Men who have sex with men
- Injection Drug Use
- Blood Recipient
- Heterosexual Sex
- Perinatal Transmission
- Hemophilia
- Other
- Unknown

Health Insurance:
- Private
- Medicare Part A/B # __________________________
- Medicare Part D # __________________________
- Medicare Part D w/ LIS – (extra help) __________________________
- VA Insurance/Tricare coverage
- MN Care
- Medicaid (MA) # __________________________
- Other
- No Insurance

If you have health insurance you must attach proof, such as a copy of your current insurance card, written notice of coverage, MN-ITS print out, etc. Proof of health insurance is needed every 6 months.

Country of Birth:
- USA
- Other: Specify __________________________
- Refused
- Unknown

Born in Minnesota:  Yes  No  If no, date you moved to Minnesota: __________________________

1. Do you feel that your nutritional needs are being met?  Yes  No
2. If no, would you like nutritional resources or referral to dietitian services?  Yes  No

By completing and signing this application I acknowledge that I have read and understand the program guidelines, payer of last resort requirements and consent to receive services from MAP. I also acknowledge I have received a copy of the MAP Client Bill of Rights, MAP Grievance Procedure and MAP Data Practices Notice. 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 __________________________
Every Penny Counts Emergency Assistance is available for low-income (see income guidelines), HIV-positive Minnesotans. Please read these guidelines carefully. Failure to complete the application or provide correct documentation will result in a delay in meeting your emergency need.

1. Eligible individuals may receive up to $400 per program year (April 1 – March 31) for the following:
   - **Rent, application fees**: Must provide copy of lease or rental agreement letter, application fee (no damage deposits, storage fees, mortgages, or foster care/nursing home fees).
   - **Moving fees**: Professional movers or U-haul rental only. Must provide an invoice.
   - **Utilities**: fuel oil, propane, gas, electric, water, and phone/cell phone bills (phone bills limited to $200 annually). Cannot pay for garbage, internet, cable bills or prepaid phone cards/prepaid phone plans. Need to submit a copy of bill/s to be paid prior to lottery. For bundled phone service you must submit a copy of the entire bill.
   - **Food**: Cub Foods gift certificates. Individuals can get up to $40 in certificates and families of 3 or more with at least 1 child can get up to $60 in certificates once per month if selected in lottery. You may call to request Cub gift certificates for a particular months lottery or you can call and request that you automatically be submitted for each monthly Cub lottery.
   - **Medical care**: doctor, hospital and clinic visits, mental health visits, home health care, substance abuse care, dental care, chiropractic care, vision care including glasses, prescription co-pays, durable medical equipment, and medical transportation (ambulance, special transportation services) that is not paid from health insurance or other sources.

2. Complete the attached application (both sides). A new application must be completed each program year (April 1, 2017 – March 31, 2018). If you request assistance more than once during the program year and have a current application on file, you do not need to complete another application for any additional request for assistance.

3. **If this is the first time you are applying** for assistance, please provide written verification of HIV-positive or AIDS status signed by a licensed health care professional.

4a. Attach **proof of the income** you report on the application such as a copy of: most recent paystub (within the last 30 days), 2016 tax return, benefit statement such as 2017 Social Security award letter, MFIP award letter, bank statement showing deposit of income, certification of zero income form or affidavit, or a MN-ITS printout indicating that you are on MA or MinnesotaCare, or a copy of your Medical Assistance card indicating that you are on Medical Assistance (MA, IM, or QI). If you have a spend down or any unusual situation with MA, we may need to collect additional income verification. Enrollment in Program HII, or a copy of your MN Health Care Programs card do not qualify as income verification for EPC. Without income documentation we will be unable to provide assistance. Please note that we need to collect updated income verification from clients every 6 months.

4b. Attach **proof of Residence** such as copy of driver’s license, state ID, current utility bill, current lease, MN-ITS printout, or a Residency Verification form if homeless, do not have a fixed address, or have a fixed address but have no documentation. Proof of Residency must be updated/collected every 6 months.

4c. Attach **proof of Medical Insurance** verification such as a copy of current insurance card, written notice of coverage, or MN-ITS printout. Proof of Medical Insurance must be updated/collected every 6 months.

4d. **Doctor visit information is needed every 6 months.**

5a. Submit a copy of the bill you want paid, and/or a copy of your lease or a letter from your landlord. Rent/moving fee requests must include a signed Hennepin County Human Services & Public Health Department/DHS Housing Related Assistance Form (Exhibit L). A copy of this form is available from HIV case managers, by contacting Every Penny Counts, or by downloading it from the MAP website. You must also submit an invoice for moving fee charges.
5b. Requests for assistance must be for **$20.00 or more**, requests that are for less than $20.00 will not be processed (exception is for prescription co-pays, medical insurance premiums & medical co-pays).

6a. **Monthly lottery**: Funds for emergency housing, emergency financial and food certificate assistance will be divided evenly by month so that the same total amount of funding is available each month. Once the allotted monthly funding has been spent on individual requests, no further assistance will be available until the following month. All requests that include all of the required paperwork (lease, rent letter, bill, etc) will be placed in the lottery. On the first business day of the month a lottery will be conducted, **requests that are to be submitted into the lottery must be submitted by Noon of the prior business day of the upcoming lottery**. Requests for assistance will **not** automatically be carried over to the next month (except for monthly food lottery requests). If your request was not selected, you must resubmit your request to be considered for the following month’s lottery. If your request was not selected and you request to have it resubmitted to the following month’s lottery, that request will go to the top of following month’s lottery.

6b. If your request for rental or utility assistance was not selected in the lottery and you receive an eviction notice and/or a shutoff/disconnection notice before the next lottery, submit a copy of the eviction notice or shutoff/disconnection notice as well as a payment plan for immediate review and possible processing. Only one disconnection or eviction notice will be allowed for review and immediate processing per client/family per funding year, after that any other disconnection or eviction notices will have to go through the regular lottery process.

7. Every Penny Counts will make assistance payments directly to the vendor and contact you by mail if the bill/ request **will not be** paid/honored.

8. In order to qualify for assistance, applicants must meet all eligibility requirements. **This service is funded by the federal Ryan White HIV/AIDS Treatment Modernization Act, Part A or B and as the Payer of Last Resort clients must have used any other available funding resources prior to accessing Every Penny Counts**

**PLEASE NOTE:**
Please call our voicemail and leave a detailed message if you have questions. We will usually return your call within one (1) working business day. Also, it can take up to 5 business days (not including the actual business day) to process your request if it is selected in the lottery and get checks or food certificates mailed out.

The Every Penny Counts voice mail greeting is updated after every lottery to reflect the status of the lottery, the availability of funding, and when the next lottery will occur. Due to holiday’s, lottery dates may be changed accordingly.

Every Penny Counts Emergency Assistance has a grievance policy, contact the MAP AIDSLine for further information.

During the grant period/year, program guidelines and the amount of funding allowed individuals is subject to change based on needs and/or the availability of funding. A notice will be sent to providers and a message will be recorded on the Every Penny Counts voicemail of any changes that occur.

**INCOME GUIDELINES FOR EVERY PENNY COUNTS EMERGENCY ASSISTANCE**
**(effective April 1, 2017)**
2017 Federal Poverty Guidelines (200%)

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Gross Annual Income</th>
<th>Gross Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$24,120</td>
<td>$2,010</td>
</tr>
<tr>
<td>2</td>
<td>$32,480</td>
<td>$2,707</td>
</tr>
<tr>
<td>3</td>
<td>$40,840</td>
<td>$3,403</td>
</tr>
<tr>
<td>4</td>
<td>$49,200</td>
<td>$4,100</td>
</tr>
<tr>
<td>5</td>
<td>$57,560</td>
<td>$4,797</td>
</tr>
<tr>
<td>6</td>
<td>$65,920</td>
<td>$5,493</td>
</tr>
<tr>
<td>7</td>
<td>$74,280</td>
<td>$6,190</td>
</tr>
<tr>
<td>8</td>
<td>$82,640</td>
<td>$6,887</td>
</tr>
</tbody>
</table>

For family units with more than eight members, add $8,360 for each additional member to annual income. “Family Unit” is defined as all people living together that are **legally dependent** on the income. Income for all members of the “family unit” will be considered for these guidelines and submitted with application.
No Income Statement

If you have no income (0), please complete.

I, __________________________________________ am receiving services from Minnesota AIDS Project (agency name)

that are funded by the Ryan White Program. Federal regulations require income verification for all program recipients.

Income includes but is not limited to:

• Gross wages, salaries, overtime pay, commissions.
• Fees, tips and bonuses
• Net income from operation of a business or from rental or real personal property
• Interest, dividends and other net income of any kind for real personal property
• Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
• Payments in lieu of earnings, such as unemployment and disability compensation, worker’s compensation, and severance pay
• Public assistance
• Alimony and child support payments (whether through the court system or not)
• Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)

I receive support through: (please check all that apply)

☐ One or more of my family members are working
☐ One or more of my family members own their own business
☐ One or more of my family members receive support other than work (Social Security, child support, Supplemental Security Income (SSI), Social Security Disability (SSDI/RSDI), spousal support, or retirement/pension income
☐ One or more of my family members gets money from a friend, relative or organization
☐ A relative, friend or organization pays all my bills and expenses
☐ I pay bills from the sale of personal items, money in a savings, checking or trust fund account
☐ I receive support from another source. Please list or provide an explanation of how you are meeting your basic needs:

________________________________________

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in this program, and may be grounds for termination of services.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing within ten (10) business days of such change.

Signature: __________________________ Date: ______________________

This document is available in alternate formats upon request.
HIV/AIDS SERVICE AGREEMENT
EXHIBIT L

Hennepin County Human Services and Public Health Department
Minnesota Department of Human Services
Housing Related Assistance Form (effective 10/1/99; revised 11/03)

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) has established the following policy for the use of Ryan White CARE Act Funds for housing referral services and/or short term emergency housing assistance:

“Ryan White CARE Act funds can only be used for housing referral and/or short term or emergency housing assistance to assist a person or family with HIV/AIDS to gain or maintain access to HIV-related medical care or treatment.”

Also, the Ryan White CARE Act must be the payor of last resort.

In an effort to document compliance with this policy, all individuals receiving housing related assistance must have the form below completed by their CASE MANAGER, SOCIAL WORKER or PHYSICIAN. Housing Related Assistance includes: Emergency Financial and Emergency Housing Assistance services from the Minnesota AIDS Project.

I, ___________________________ certify that the following conditions have been met for ___________________________ to receive housing related assistance:

- Other sources of housing related assistance have been exhausted. For example, City, County, State or Federal Programs and those included on attached Emergency Housing Resources List.
- A care plan is in place for the above client which includes goals and objectives related to securing long term permanent and stable housing; and
- The client requires housing related assistance to enable him/her to gain and/or maintain access to medical care.

Signed:

Case Manager/Social Worker/Physician

Date: ________________

Client

Date: ________________

This completed form should be kept with the client’s confidential case management file and updated every six months.
Residency Verification

Client Name: ____________________________

Only for clients who: Do not have a fixed address or are homeless; or

(a) Have a fixed address but no documentation

<table>
<thead>
<tr>
<th>(a) No fixed address/homeless</th>
<th>(b) Fixed address/no documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I do not have a fixed address</td>
<td>☐ I have a fixed address and am unable to provide documentation</td>
</tr>
<tr>
<td>I am residing in the city of:</td>
<td>Please explain why you are unable to provide the required documentation (residing in transitional housing, not on a rental agreement, etc.)</td>
</tr>
<tr>
<td>I most often stay at the following locations:</td>
<td></td>
</tr>
<tr>
<td>Mailing address:</td>
<td>Residential address:</td>
</tr>
<tr>
<td></td>
<td>Mailing address (if different from residential):</td>
</tr>
</tbody>
</table>

I am a resident of Minnesota and all statements regarding my housing status are true. I understand that false or misleading information affects my eligibility for Ryan White Care Act funded programs offered by the Minnesota AIDS Project and may result in my termination from them.

__________________________________________  ________________________
Client signature                                  Date
AUTHORIZATION TO EXCHANGE INFORMATION

I hereby authorize ____________________________ at the Minnesota AIDS Project to exchange information regarding:

__________________________ with

__________________________

Organization/Individual Phone Number

(address)

Note: Client to initial each item indicating authorization or write “N/A” if not applicable

Purpose:

To provide and coordinate services

Verification of diagnosis

Medical information related to date of diagnosis/information regarding ongoing medical care

Services provided by the Minnesota AIDS Project

Psycho-social factors including, but not limited to, housing, financial status, hospitalizations, and alcohol and drug use

Medical history

Home care information

Mental health/psychological history

Program eligibility verification

Coordination of Care

Other information to include:

__________________________

I understand that this information will be kept in a confidential manner by the Minnesota AIDS Project staff and trained volunteers.

I have been informed of my right to refuse to allow MAP to exchange this information.

I understand that I may revoke this consent upon written notice. The revocation will be effective the day it is received by the staff person named on this release or his/her successor.

I understand a photocopy or fax of this form is the same as the original.

I understand I may have a copy of this form after I have signed it.

I understand that information may be exchanged via phone, fax, email or a meeting with provider.

I understand that the consent will automatically expire within one year after the date of my signature below, if an earlier date is not specified.

__________________________

Name (Please print)

__________________________

Signature Date

This document is available in alternate formats upon request.
Minnesota AIDS Project Client Bill of Rights

As a client of the Minnesota AIDS Project, you have the right to:

1. Be treated with consideration and respect by staff, volunteers and interns of MAP. You have the responsibility to treat MAP staff, volunteers and interns in a similar manner.

2. Quality services without discrimination regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender or disability.

3. Confidentiality of information we collect about you. No identifying information about you will be shared outside of MAP without a release of information dated and signed by you listing individuals and agencies with whom you have agreed to have us share information by fax, phone, email or meeting and that all releases will be renewed if needed, on an annual basis. Any exceptions are outlined in the data practices guidelines. All records and files pertaining to the services you receive at MAP will be kept in locked filing cabinets and/or secure computer files when not in use.

4. Review all private information in your file and obtain a copy of this information. If you request a copy, the request must be in writing and signed by you. We will not give or send a copy of your file to any other person without a signed release from you except if we receive a valid court order.

5. Expect reasonable assistance to overcome language, cultural, physical or communication barriers. This means for example, that upon request MAP will provide interpreters for the deaf and for those who do not speak English.

6. Prompt and reasonable response to your questions and requests.

7. Participate in developing your service plan including developing service goals that meet your needs.

8. Prompt Information on how to make complaints and pursue a grievance if you are having difficulties or are dissatisfied with the services you are receiving.

9. Refuse services or recommended services and to discontinue services at MAP.

10. Receive timely notice and explanation of changes in program guidelines including changes in eligibility criteria and funding availability.

If you have questions about MAP services, or would like to make a suggestion, you may do so with your service provider, the program manager, or the director of programs.

Specific MAP programs or services may have additional rights and responsibilities that will be made available to you upon entry into the program.

As a provider of services, the Minnesota AIDS Project will:
- Determine your eligibility to receive and to continue services.
- Assign the staff, volunteers or interns who will work with you.
DATA PRACTICES NOTICE

This notice is given and/or reviewed with all MAP clients. For the purposes of this document, clients are defined as those persons receiving reportable services including MAP AIDSLine Quick Connect, case management, transportation, housing services, legal services, benefits counseling, chemical health services, Every Penny Count Emergency Assistance, Positive Link/HERR Support, PrEP Navigation and other support services.

As a client of the Minnesota AIDS Project certain laws including the right to privacy protect you. The Minnesota Government Data Practices Act provides you with rights about data obtained from you. The data we collect at MAP is, in nearly all cases, considered private data, which means you have access to it. The Minnesota AIDS Project is aware of the sensitive and private nature of much of the information that is shared between clients and MAP staff. MAP as an agency, is committed to maintaining and protecting your confidentiality.

Why MAP Collects Data

- To assess your individual situation and coordinate services for you. These services may be at MAP or they may be services you receive from other agencies;
- To assess the effectiveness of MAP’s services;
- To verify to funding sources that MAP is providing services and the outcome of those services;
- To determine your eligibility for services offered by MAP and other agencies;
- To make appropriate referrals.

Information about you may be exchanged among MAP staff and volunteers as needed to coordinate services for you. Additionally, client records may be reviewed for the following reasons:

- Supervisors, agency attorneys or consultants to make sure you are receiving the best possible service;

Clients receiving services funded in whole or part through the Ryan White program will have demographic data about them including their names, sent to the Minnesota Department of Health (MDH). Additionally, the Minnesota Department of Human Services and Hennepin County Ryan White Program will have access to information sufficient to carry out payment, treatment and operations as specified by the HIV/AIDS Bureau of the U.S. Department of Health & Human Services Health Resource and Service Administration (HRSA). These organizations maintain this information in a confidential manner and do not share your name with any other entities.

Right to Refuse and Consequences of Refusal

You have the right at any time to refuse to share information about yourself with MAP staff. Generally this will not affect the services you are receiving. However, in some cases, there is the possibility that MAP will be unable to provide some type of service to you unless we have certain information. MAP staff will let you know if your refusal to share information will affect the services that can be provided.

MAP provides information to agencies and government offices that provide funding to MAP. The Minnesota Department of Health HIV/STD Services Division, federal and state program compliance auditors, the Minnesota Department of Human Services HIV/AIDS Division Programs, Housing and Urban Development (HUD), Hennepin County Adult Services, Hennepin County Public Health and Human Services, the Minnesota Housing Finance Agency and the City of Minneapolis and other persons or entities authorized by law to collect data may also review client records to monitor the services provided by MAP. The same law that gives you privacy prohibits these persons or entities from releasing information about you once they have received it.

MAP staff are mandated reporters meaning there are circumstances when they are required to report suspected child abuse or neglect, threats to others or self, or suspected abuse or neglect of vulnerable adults to social services or law enforcement. Other than these circumstances and as outlined above, MAP cannot use or release information without your express written or verbal permission.

My signature below means that I have read this document and have also been offered a copy of this information.

Client Signature __________________________ Date __________

(Staff initial and date if no client signature)

This document is available in alternate formats upon request.

Adopted: 8/94; Last revised: 4/16 W:\2017\EP\Cappsandguidelines\Data Practices Notice for clients.docx
1. Any person receiving services from the Minnesota AIDS Project may voice comments, concerns, or grievances directly to the staff person they are working with or to that staff person’s supervisor.

2. If your comment, concern or grievance was not addressed to your satisfaction, you may arrange a meeting with or submit a written statement to the Director of Programs. The MAP staff person you talked with will provide the contact information including the name, address and phone number of the Director. Your written statement or request for a meeting must be received within two weeks of the date you last addressed this issue or concern with the staff person or their supervisor.

3. You will receive a written response within 30 days after we with you receive your written statement. This written decision is the final decision of MAP.

4. Some programs offered by the Minnesota AIDS Project are funded through contracts with various government agencies that will also accept your grievance if your concern or grievance has not been settled to your satisfaction. Information with the appropriate name and contact information at each agency is available upon request or will be mailed to you within one working day of your written or verbal request for it.

This document is available in alternate formats upon request.