

**Every Penny Counts Emergency Assistance for Housing Assistance in Greater Minnesota**

**I am applying for: (check one)**

- Emergency rental assistance**
- Emergency mortgage assistance**
- Utility assistance**

**Amount requested: \$ \_\_\_\_\_**

**Gr. MN client # \_\_\_\_\_**

**PE client # \_\_\_\_\_**

**For Office use**

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

\_\_\_\_\_ ( )  
 Last name First name Middle initial phone # - include area code

\_\_\_\_\_ Address street and number

\_\_\_\_\_ City County State Zip

\_\_\_\_\_ Payee's name Type of agency (landlord, bank, utility)

\_\_\_\_\_ Payee's address street and number

\_\_\_\_\_ City State Zip

The Minnesota Housing Finance Agency (MHFA) requires 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 services, to evaluate future funding needs. You have the right to refuse to share information about yourself however EPCEA may be unable to provide assistance to you without this information. Your name and other identifying information is not released to the Minnesota Housing Finance Agency.

**Please initial that you have read and understand the paragraph above: \_\_\_\_\_**

**Applicant information:**

Applicant's Date of birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Applicant's gender: \_\_\_ Male; \_\_\_ Female; Transgender: \_\_\_ Female to Male \_\_\_ Male to Female

\*\* Chronically Homeless \_\_\_ Yes \_\_\_ No Veteran (of active duty): \_\_\_ Yes \_\_\_ No

Number of bedrooms (BDRM) in home/living space (mark one):

Studio \_\_\_ 1 BDRM \_\_\_ 2 BDRM \_\_\_ 3 BDRM \_\_\_ 4 BDRM \_\_\_ 5 + BDRM \_\_\_

**Applicant's race/ethnicity – please check all that apply:**

- American Indian/Alaskan Native  White (not Hispanic)  Black/African America (not Hispanic)  Asian
- Hawaiian/Pacific Islander  Hispanic/Latino/Chicano  American Indian & White  Asian & White
- Black/African America & White  American Indian & Black/African America  Other Multi Racial

Please list the age, gender, and race/ethnicity for each additional household member/s other than yourself that are dependent on your income:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(over, please complete back side, 2<sup>nd</sup> page)

Referred by (agency, case manager, service provider) \_\_\_\_\_

All four of the following housing plan questions must be answered in order to receive assistance.

1. Please describe the nature of the housing emergency:

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2. Please explain how expenses will be met once assistance has ended:

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3. How will you meet future housing needs in order to have stable housing?

By utilizing (check all that apply):

- County economic assistance  
 Other emergency assistance financial assistance services  
 Working with a service provider on maintaining housing  
 Looking for more affordable housing  
 Other(explain) \_\_\_\_\_

4. You must apply for all public assistance programs for which you are eligible prior to submitting this application. Have you done this?  Yes  No

Income Verification Form must be completed and returned with this application.

**I authorize my Case Manager/Social Worker/HIV provider to exchange information with EPCEA staff regarding financial assistance: \_\_\_\_\_ (initial)**

**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.** Submission of this application and my signature below constitutes consent to receive services and acknowledges that I have received a copy of the Client Bill of Rights, Data Practices Notice and Grievance Procedures.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

**Mail or fax completed application to:** Every Penny Counts Emergency Assistance

P. O. Box 582943  
Minneapolis, MN 55458  
(612) 331-7733  
(800) 565-9028  
(612) 341-3804 – fax

\*\* Chronically Homeless is defined as an individual age 18 or older with a disabling condition that has been "sleeping in a place not meant for human habitation (e.g., living on the streets) or in an emergency homeless shelter", who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years.

**For Office use only:** Application reviewed for eligibility: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff initial:

## **GUIDELINES FOR GREATER MINNESOTA HOUSING ASSISTANCE**

The Minnesota AIDS Project (MAP), through Every Penny Counts Emergency Assistance, provides emergency assistance for housing to HIV-positive persons/households in Greater Minnesota. This program is funded through Housing Opportunities for Persons with AIDS (HOPWA) and is administered by the Minnesota Housing Finance Agency (MHFA). This assistance is designated for eligible persons living in Greater Minnesota only. The household must be facing a housing crisis due to HIV or related issues and meet all other eligibility criteria.

Funding for this program is determined by the state of Minnesota and may not be renewed at the end of the grant period. During the grant period program guidelines may change based on needs and/or availability of funds.

All applicants will be referred to MAP's Every Penny Counts Emergency Assistance (EPCEA) coordinator for assessment of housing related financial emergency.

### **Eligibility Guidelines:**

1. Applicant household must be in Greater Minnesota outside of the following Minnesota counties: Hennepin, Ramsey, Washington, Scott, Dakota, Carver, Anoka, Chisago, Isanti, Wright and Sherburne.
2. Household must be at or below 80% of the Minnesota County statistical median income guideline as defined by HUD.
3. At least one household member must be HIV positive.
4. Applicants must apply for all public assistance programs for which they are eligible prior to completing this application.
5. Requests for assistance must be for \$20.00 or more.

### **Documentation Requirements for all applicants:**

1. First time applicants must provide written verification of HIV status; this may be a statement from a physician, case manager, social worker or HIV service provider.
2. All applicants must submit verification of gross household income from all household members – i.e.: self, spouse, domestic partner, dependent children. Acceptable documentation includes: A Social Security benefit statement, Public Assistance (ie: GA, MFIP, etc), a bank statement showing deposit of income, current pay stub, earned income from assets (cash value of \$5000 or more), or a zero income certification form. All family members who are 18 and older and are without income must sign a zero income form. The Income Verification Form must be completed and returned along with supporting income verification documentation when submitting application.
3. Applicant must complete the application form and sign it. Incomplete applications including those without all the required paperwork and documentation will not be processed.
4. MHFA (funding source) requires that some personal information be collected and reported to it for the following purposes:

- \* to identify the services persons with HIV disease need and use
- \* to identify barriers to those services
- \* to evaluate future funding needs

Applicants have the right to refuse to sign the application, which allows the release of information to the MHFA, however it will prevent their participation in the program.

**Assistance Categories:** There are three categories of assistance available through this program: **Emergency Rental Assistance, Emergency Mortgage Assistance, and Utility Assistance.** Below is the information regarding each category including the documentation needed to complete the application:

### **Emergency Rental Assistance**

1. Provide a copy of the rent/lease agreement. (Funds cannot pay security deposits or 1<sup>st</sup> month's rent). If applicant lives with and pays rent to a family member, income verification of all household members is required.
2. Assistance up to \$800 is available for **one** month's rent within a 12 month period.
3. Assistance for the same amount can be provided for a second month if the need is clearly demonstrated.
4. Rent assistance is paid directly to the landlord.
5. **Applicants receiving any form of a rental subsidy, do not qualify for rent assistance from the Gr. MN Housing Assistance program.** Rent assistance payments cannot be made for an individual or household that is already receiving rental assistance through a federal, state, or local housing subsidy program. Apply for rental assistance through the Gr. MN Every Penny Counts program.

### **Mortgage Assistance**

1. Provide mortgage information/payment stub.
2. Assistance up to \$ 800.00 is available for **one** month's mortgage payment within a 12 month period.
3. Assistance for the same amount can be provided for a second month if the need is clearly demonstrated.
4. Mortgage assistance is paid directly to the mortgage company/lender.

### **Utility Assistance**

1. Submit the utility bill or copy of the bill (accepted utility bills are: electric, heating fuel, natural gas, propane, or water bills). **No assistance for phone, cable, internet or garbage bills.**
2. Assistance up to a maximum of \$250 is available for utility bills within 12 months.
3. Applicants must have utility bill accounts in their name or proof of responsibility to make utility payments (copy of money order, cancelled check, receipt/ letter from named person on the utility bill).
4. Payment is made directly to the utility company.

**PLEASE NOTE: You cannot be selected more than 3 times from the lottery in a year for all assistance.**

**For all assistance categories:** Requests that include all the required paperwork and documentation and have been submitted no later than **noon** on the business day prior to the upcoming monthly lottery will be submitted for assistance. On the first business day of the month, a lottery will be conducted. Once the allotted monthly funding has been distributed, no further assistance will be available until the following month. Applicants not receiving assistance will be notified by mail and may resubmit requests for the following month's lottery. Allow up to 5 business days to process requests once the lottery is completed.

### **Application process:**

1. Complete and sign the application form
2. Provide medical verification of HIV status (1<sup>st</sup> time applicants only)
3. Provide gross income verification on all household members. All family members residing in the household who are 18 and older and are without income must sign a zero income form. The Income Verification Form must be completed and returned with the application.
4. Provide the required paperwork for funding assistance requested (lease, mortgage coupon, utility bill) and submit to Every Penny Counts Emergency Assistance.
5. All eligible applicants for whom complete applications have been received will be placed in a lottery on the first business day of the month.
6. Every Penny Counts voice mail greeting is updated after every lottery to reflect the status of the lottery, the availability of funding, and the date of the next lottery.

**Every Penny Counts Emergency Assistance (EPCEA)**

**P. O. Box 582943, Minneapolis, MN 55458**

**(800) 565-9028 or (612) 331-7733**

**(612) 341-3804 – fax**

## Income Verification Form

**This form must be completed and returned along income verification documentation with the Gr. MN Housing Assistance application.**

HOPWA Income Sources: Documentation/Verification of all **family household members'** income is required:

\*1. Income sources:

- Wages & salaries, overtime pay, commissions, tips, & bonuses, unemployment, worker's comp., severance pay etc. If a household member is 18 years or older and is a full time student and employed only \$480.00 of earned income will be included in this calculation.
- Social Security, Welfare Assistance (excludes food stamps), GA or any federal, state, local government benefits/assistance, pensions, retirement funds, long term disability or death benefits, etc.
- Alimony, child support, regular cash gifts received from a organization or person not residing in household
- Net income from operation of a business or profession
- Regular or special pay, and allowances from the Armed Forces (excludes hostile fire pay)

\*2. Assets – a cash or non-cash item that can be converted to cash. Assets must have a cash value of \$5000 or more to be included as income and only the earned income/interest is counted. Examples: checking and savings accounts, insurance policies, dividends, rental property, stocks, bonds, etc.

Circle any assets that you or a household member have or check the no asset category

Cash	Equities	Stocks/bonds	Deeds	Checking/savings account
Retirement accounts		Life insurance	Personal property	
_____ I have no assets				

If you have identified an asset above what is the anticipated annual earned income/interest?

\_\_\_\_\_

**A zero income form needs to be completed by any household member that is 18 and over and has no income.**

\*1. Annual Income from wages, SSI, government benefits, etc.: \$ \_\_\_\_\_

\*2. Annual Asset earned income/interest: \$ \_\_\_\_\_

**Total annual household income:** \$ \_\_\_\_\_

**Total monthly gross household income:** \$ \_\_\_\_\_

Number of dependents on income: \_\_\_\_\_ (self, spouse, domestic partner, dependent children)

Number of individuals in household living with HIV/AIDS: \_\_\_\_\_

Number of individuals living in the household all together: \_\_\_\_\_

Client Name (Please print): \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO EXCHANGE INFORMATION**

I hereby authorize \_\_\_\_\_ at the Minnesota AIDS Project  
(Name)  
to exchange information regarding:

\_\_\_\_\_ with  
(Name) (Date of Birth)

\_\_\_\_\_ (Phone Number)  
(Organization /Individual)

\_\_\_\_\_  
(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)

\_\_\_\_\_ Date  
Signature

This document is available in **alternate formats** upon request.

## **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.

## 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 through MAP AIDSLine Quick Connect, CLEAR counseling, case management, transportation, housing services, legal services, benefits counseling, chemical health services, Every Penny Count Emergency Assistance, or Positive Link.*

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, Coordinated Care Network, 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.

This document is available in **alternate formats** upon request.



## **Minnesota AIDS Project GRIEVANCE PROCEDURE**

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.

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