Statewide Housing Assistance program
(SHA program)
PO Box 582943
Minneapolis, MN 55458
(612) 331-7733 - Metro Area
(800) 565-9028 - Greater MN
(612) 341-3804 - Fax epc@justushealth.mn - email
See attached guidelines and eligibility criteria form

EPC Client # _____
PE Client # _____
(for office use only)
7/1/18 – 6/30/19
Prior forms no longer valid
*****This application is only for Statewide Housing Assistance (SHA)**

Please complete all information requested on this form. Incomplete applications may not be processed. This application can only be used when applying for the SHA program.

First Name | Middle Name | Last Name

Address | Apt | County
☐ YES ☐ NO

City | State | Zip *(Required)* | OK to Send Mail (*envelopes do NOT say "MAP"*)

Phone (s) include area code | **Birthdate (MM/DD/YY)**

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, SSI, 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:

☐ **Option 1**

Attach documents showing proof of income such as a copy of: your most recent pay stub (within the last 30 days), a 2017 tax return, certification of zero income form or affidavit, a benefit statement such as a 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.

☐ **Option 2:**
If you are on Medical Assistance (MA, IM, QI, etc) or MinnesotaCare you may send a MN-IT'S 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.
Please Note: enrollment in Program HH, or a copy of your MN Health Care Programs card do not qualify as income verification for EPC.

☐ **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 Utility Bill
☐ Current Lease agreement
☐ Mortgage statement/coupon
☐ MN-ITS printout

Race (*Select one or more*):

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

Ethnicity (Select one):

☐ Hispanic/Latino ☐ Not Hispanic/Latino

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

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 or (800) 248-2437 for a physician referral.

Exposure Category: Select one or more

☐ Men who have sex with men ☐ Hemophilia
☐ Injection Drug Use ☐ Blood Recipient ☐ Other
☐ Heterosexual Sex ☐ Perinatal Transmission ☐ Unknown

Health Insurance: Select one or more

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

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?** _____

This program was made possible with funding provided by the Minnesota Department of Human Services.

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

_____ _____
Signature Date

Statewide Housing Assistance program 2018-2019 Guidelines

(SHA program)
PO Box 582943
Minneapolis MN 55458

612-331-7733
1-800-565-9028 (Toll free)
612-341-3804 – fax,
epc@justushealth.mn - email

Statewide Housing Assistance (SHA) is available for HIV-positive Minnesotans with income at or below the 400% FPG for security deposits and application fees, as well as mortgage assistance for **Metro area clients.**
Rental assistance is available for HIV-positive Minnesotans between 201% and 400% FPG.
Please read these guidelines carefully. Failure to complete the application or provide correct documentation will result in a delay in meeting your emergency need. Must use the SHA program application to apply for this assistance.

1. Eligible individuals/households may receive assistance during the program year (July 1 – June 30) for the following:

   Statewide Rent: (only for individuals between 201% to 400% of FPG)
   Individuals may receive up to $600 for rental assistance during the funding year. Must provide a copy of lease or rental agreement letter that includes cost of a month's rent to receive assistance. Assistance is paid directly to vendor.

   Statewide Security Deposit: (for individuals at or below 400% of FPG)
   Up to $800 for security deposit once during the funding year per household. The request must be for pending and immediate move in or within 90 days of the move in date on the lease. Must provide a copy of initial lease that includes cost of security deposit to receive assistance. Assistance is paid directly to vendor.

   Statewide Application fees: (for individuals at or below 400% of FPG)
   Individuals may receive up to $75.00 for application fees during the funding year. Must submit an application fee bill/invoice to receive assistance. Not able to reimburse individuals for out of pocket cost for application fees, must pay vendor directly.

   Metro Mortgage Assistance: (for individuals at or below 400% of FPG)
   Mortgage assistance is only for households living in the 11 county Metro area (Hennepin, Ramsey, Dakota, Scott, Anoka, Carver, Washington, Isanti, Sherburne, Wright and Chisago). Assistance up to $800.00 for one month's mortgage per household per funding year. SHA will only pay what the mortgage is or up to $800 if mortgage is higher. A second month of mortgage assistance maybe provided in an extreme emergency to prevent a foreclosure and is subject to funding availability. Must provide a copy of mortgage statement or mortgage payment coupon with client's name on it for assistance. Assistance is paid directly to the mortgage company/lender.

2. Complete the attached application (both sides). A new application must be completed each program year (July 1, 2018 – June 30, 2019). 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), 2017 tax return, benefit statement such as 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, MinnesotaCare or Program HH. 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 or mortgage statement, 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/lab visit information is needed every 6 months.**

5. **Monthly lottery:** May be established depending upon the demand for financial assistance.

6. Every Penny Counts will make assistance payments directly to the vendor.

7. In order to qualify for assistance, applicants must meet all eligibility requirements. **This program was made possible with funding provided by the Minnesota Department of Human Services.**

PLEASE NOTE:
Please call our voicemail and leave a detailed message if you have questions. We will usually return your call within one working business day but in some cases, can be up to two working days. Also, will we attempt to process your financial request in 3 business days or less.

The Every Penny Counts voice mail greeting is updated after ever lottery to reflect the status of the lottery, the availability of funding, and when the next lottery will occur.

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

During the grant period/year, program guidelines and the amount of funding allowed per individuals/households 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 Statewide Housing Assistance

2018 Federal Poverty Guidelines (400%)

Family Size	Gross Annual Income	Gross Monthly
1	$48,560	$4,047
2	$65,840	$5,487
3	$83,120	$6,927
4	$100,400	$8,367
5	$117,680	$9,807
6	$134,960	$11,247
7	$152,240	$12,687
8	$169,520	$14,127

For family units with more than eight members, add $17,280 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 must be submitted with application.

INCOME GUIDELINES FOR Statewide Housing Rental Assistance

2018 Federal Poverty Guidelines (201% to 400%)

Family Size	Gross Annual Income – 201%	Gross Monthly - 201%	Family Size	Gross Annual Income – 400%	Gross Monthly – 400%
1	$24,281	$2,024	1	$48,560	$4,047
2	$32,921	$2,744	2	$65,840	$5,487
3	$41,561	$3,464	3	$83,120	$6,927
4	$50,201	$4,184	4	$100,400	$8,367
5	$58,841	$4,904	5	$117,680	$9,807
6	$67,481	$5,624	6	$134,960	$11,247
7	$76,121	$6,344	7	$152,240	$12,687
8	$84.761	$7,064	8	$169,520	$14,127

For family units with more than eight members, add $17,280 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 must be submitted with application.

No Income Statement

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

I, _____ am receiving services from

_JustUs Health_____
(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.

JustUs Health
2577 Territorial Road
St Paul, MN 55114

justus health™

Residency Verification

Client Name: _____ Date of Birth: _____

Only for clients who:

(a) Do not have a fixed address or are homeless; or
(b) Have a fixed address but no documentation

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

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 JustUs Health and may result in my termination from them.

_____ _____

Client signature Date

AUTHORIZATION TO EXCHANGE INFORMATION

I hereby authorize _____ at JustUs Health to exchange information regarding:
(Name)

_____ _____ with
(Name) (Date of Birth)

_____ _____
(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 including:

_____ Verification of diagnosis
_____ Medical information related to date of diagnosis/information regarding ongoing medical care
_____ Services provided by JustUs Health
_____ Psycho-social factors including, but not limited to, housing, financial status, hospitalizations, home care needs and alcohol and drug use
_____ Medical history
_____ Chemical health assessment, diagnosis and recommendations
_____ 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 JustUs Health staff and trained volunteers.
I have been informed of my right to refuse to allow JustUs Health 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 named on this release or his/her successor. I understand that information shared prior to revocation can't be retracted.
I understand that when health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
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.

DATA PRACTICES NOTICE

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

As a client of JustUs Health 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 JustUs Health is, in nearly all cases, considered private data, which means you have access to it. JustUs Health is aware of the sensitive and private nature of much of the information that is shared between clients and JustUs Health staff. JustUs Health as an agency, is committed to maintaining and protecting your confidentiality.

Why JustUs Health Collects Data

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

Information about you may be exchanged among JustUs Health 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: name, date of birth, race, ethnicity, gender, zip code, income level, insurance and housing status, HIV/AIDS diagnosis dates and related medical information) 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 JustUs Health staff. Generally this will not affect the services you are receiving. However, in some cases, there is the possibility that JustUs Health will be unable to provide some type of service to you unless we have certain information. JustUs Health staff will let you know if your refusal to share information will affect the services that can be provided.

JustUs Health provides information to agencies and government offices that provide funding to JustUs Health. 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, Centers for Disease Control and other persons or entities authorized by law to collect data may also review client records to monitor the services provided by JustUs Health. The same law that gives you privacy prohibits these persons or entities from releasing information about you once they have received it.

JustUs Health 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, JustUs Health 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.

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Advocacy. Care. Justice. Pride.

JustUs Health Client Bill of Rights

As a client of JustUs Health, you have the right to:

1. Be treated with consideration and respect by staff, volunteers and interns of JustUs Health. You have the responsibility to treat JustUs Health 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 JustUs Health 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 JustUs Health 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 JustUs Health 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 JustUs Health.

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

If you have questions about JustUs Health 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 JustUs Health 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, JustUs Health will:

- Determine your eligibility to receive and to continue services.
- Assign the staff, volunteers or interns who will work with you.

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JustUs Health
GRIEVANCE PROCEDURE

1. Any person receiving services from JustUs Health 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 Program Director of the service your grievance is connected to. The JustUs Health staff person you talked with will provide the contact information including the name, address and phone number of this 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 JustUs Health.

4. Some programs offered by JustUs Health 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.