

MAP Transportation Program Application

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

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

Case Manager/Social Worker: _____ Phone #: _____

I authorize my Case Manager/Social Worker/HIV provider to Exchange information with Transportation staff regarding transportation needs/services: _____ (initial)

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 or lease agreement.

- | | |
|---|--|
| <input type="checkbox"/> Copy of driver's license / MN State ID | <input type="checkbox"/> Current Lease agreement |
| <input type="checkbox"/> Current Utility Bill | <input type="checkbox"/> Read and sign MAP Residency Verification Form |

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

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

You must provide documented 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:** I am attaching documents showing proof of income such as a copy of: the most recent pay stub for all family members (within the last 30 days), last year's tax return/s, benefit statement/s such as a Social Security award letter or county statement, MFIP award letter, or a bank statement/s showing deposits, MN-ITS printout showing MA, MNCare, or Program HH, etc.
- Option 2:** I have zero income and I have completed and attached the Certification of Zero Income.

Living Situation: Stable / Permanent Temporary Unstable

Race (Select one or more):

- | | | | |
|---|--|---|----------------------------------|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian | <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Unknown |

Ethnicity (Select one):

- Hispanic/Latino Not Hispanic/Latino Unknown

[Be sure to complete the 2nd page/backside of this application – check reverse side]

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 Check box if Estimated date of HIV diagnosis

Date of AIDS Diagnosis _____ Month/ Day/ Year Check box if Estimated date of AIDS diagnosis

You must attach proof of HIV/AIDS status to this application, which can be a lab report or signed form from a physician if this is your first time applying.

When was your last visit to your HIV doctor/lab work?:

Month/Day/Year of appointment: _____

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

Exposure Category:

Select one or more

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

Health Insurance:

Select one or more

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

Date Client Moved to MN: _____

By completing and signing this application I acknowledge that I have read and understand the program guidelines, payer of last resort requirements and I consent to receive services from MAP. I also acknowledge that 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

Return to: MAP
Attn: Transportation Program
2577 Territorial Road
St. Paul, MN 55114

Metro Area Transportation Program Guidelines

The Minnesota AIDS Project (MAP) Metro Area Transportation Program provides door-to-door rides for HIV+ individuals whose income is at or below 400% FPG and live in the 7 county Metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties). Taxis provide rides to medical and mental health appointments, lab work, social service appointments, and medication pick-ups from pharmacies, etc. when no other transportation services are available to them through MNET, clinic or other service provider as the MAP Transportation Program is the Payer of Last Resort. Please contact the Transportation Program for a complete list of current ride types available. Food shelf deliveries are available when there is a volunteer able to provide them. Rides are scheduled on a first come, first served basis, and based on funding availability. Priority will be given to medical appointment rides. Hennepin County Human Services and Public Health funds this service through the Ryan White HIV/AIDS Treatment Extension Act of 2009. Funding availability will dictate what ride types are being offered and the funding may or may not be renewed at the end of the grant period. During the grant period program guidelines may change based on needs or availability of funds.

- Rides are available Monday through Friday from 8:00 a.m. to 5:00 p.m. (except holidays).
- Call **(612) 373-2430** to request a ride.
- Rides must be arranged at least 48 hours (2 working days) in advance. If you know about an appointment earlier, call and we will schedule it up to 2 months in advance.
- **When asking for a ride you need to give us:**
 - Your name, address, phone number;
 - Date and time to pick you up;
 - The address of where you need to go;
 - Any special needs you may have (for example: you use a wheelchair or walker, need a taxi with a child car seat, need a mini-van instead of a sedan taxi or someone will be going with you).
- If you cannot make a scheduled ride you need to let the Transportation Program know at least one hour before the ride. Call us at 612-373-2430. If you miss three rides without telling us, you will not be able to use the transportation program for 30 days.
- You must be ready and waiting for the driver at the pre-arranged time and place, either outside or watching from a window in order to walk out the door when the driver pulls up to the curb. Drivers will not come to your door to pick you up, and may or may not call you when they arrive. The Taxi company charges our program per minute of wait time, and both taxis and volunteers will leave after waiting five to ten minutes. If you are not on time for your taxi and it leaves, the Transportation Program will not send another taxi for you on that day.
- If you are disruptive, drivers have the right to end a ride in progress. Foul language and actions towards staff, taxis and/or volunteers will not be tolerated. This will result in your not being able to use the program.
- For your safety, we may cancel rides due to bad weather and roads. We will call you if we need to cancel your ride.

- This is basically a “curb to curb” service; clients will need to be able to access the vehicle and destination without assistance from the driver. If you need additional assistance, let us know and we can send you a wheelchair accessible taxi van that can assist you “door through door”.

Bus Cards: MAP Transportation can provide bus cards for use by HIV-positive individuals who do not have access to them from a case management program or clinic. Eligible individuals may receive a maximum of 2 bus card per calendar month, based on proof of need. Bus cards are provided to assist individuals in reaching medical appointments, support services, case management appointments, food shelf and congregate meals. Contact MAP Transportation for more information.

To sign up for basic Metro Transportation Services, the following paperwork is required:

- The “**HIV Verification**” form must be completed and signed by a medical doctor, OR we will accept other proof of HIV diagnosis such as a letter from a doctor or lab report which states that the client is HIV positive.
- The “**Data Practices**” form must be read and signed by the client.
- The “**Payer of Last Resort Agreement**” must be read and signed by the client every 6 months.
- All pages of the “**Transportation Application**” must be completed and the last page signed by the client.
- Attach **proof of the income** you report on the application such as a copy of: most recent paystub (within the last 30 days), last year’s tax return, benefit statement such as Social Security award letter, MFIP award letter, bank statement, MN-ITS print out if on MA, MNCare, Program HH or Certification of Zero Income form or affidavit. 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.
- Attach **proof of Residency** 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.
- Attach **proof of Medical Insurance** verification such as a copy of a current insurance card, written notice of coverage, or MN-ITS printout. Proof of Medical insurance must be updated/collected every 6 months.
- The “**Authorization to Exchange Information**” form must be completed and signed by the client if they want the MAP Transportation Program to be allowed to speak with their clinic, case manager, family member, partner or any other person about their services. This form must be updated annually.
- The “**Minnesota AIDS Project Client Bill of Rights**” form must be given to the client.
- Some clients may qualify for a bus card; they must sign the “**Bus Pass Agreement**” form, which must be updated annually, to receive this service.

If you have questions or concerns about the MAP Transportation Program, please call 612-373-2430.

Here is a list of some of the ride types that the MAP Transportation Program can offer depending on funding availability: Medical/Doctor, Lab work, Mental Health, Benefits Counseling, HIV Medical Case Management, Pharmacist/Medication pick-ups, Chemical Dependency, Dentist, Chiropractor, Dialysis, Nutritionist, Psychiatrists, Physical/Speech Therapy, Support Groups, Eye Care, foodshelf, etc. Please call the Transportation Program to find out what ride types are currently being offered – 612-373-2430.

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.

MAP Transportation Program Payer of Last Resort Agreement

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) has established the following policy for the use of Ryan White HIV/AIDS Treatment Extension Act of 2009 funds for medical transportation services:

These funds can only be used for medical transportation to assist a person with HIV / AIDS to gain or maintain access to HIV-related medical care or treatment.

Also, the Ryan White HIV/AIDS Treatment Extension Act of 2009 must be the payer of last resort. By signing this form I understand that I may use MAP's medical Transportation Services only when I have no other transportation services available.

Signed:

Client Name

Date Signed

**MAP Transportation Program
BUS CARD AGREEMENT**

I am applying for a bus card at the Minnesota AIDS Project because I am not currently eligible for a bus card at any other agency. I agree to use the bus passes provided to me for only the following purposes: Rides to medical appointments, support services and case management appointments.

I will inform MAP's transportation staff if I become eligible for bus cards through any other program.

This agreement is valid for one year from the date of signature, or less time if circumstances change.

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

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: _____

Minnesota AIDS Project
1400 Park Avenue
Minneapolis, MN 55406



Residency Verification

Client Name: _____

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
<p><input type="checkbox"/> I do not have a fixed address</p> <p>I am residing in the city of:</p> <p>I most often stay at the following locations:</p> <p>Mailing address:</p>	<p><input type="checkbox"/> I have a fixed address and am unable to provide documentation</p> <p>Please explain why you are unable to provide the required documentation (residing in transitional housing, not on a rental agreement, etc.)</p> <p>Residential address:</p> <p>Mailing address (if different from residential):</p>

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



HIV VERIFICATION & MEDICAL INFORMATION

I hereby certify that _____ has
(Name and D.O.B.)
been tested and diagnosed as follows:

_____ HIV+, Asymptomatic

_____ HIV+, Symptoms: _____

_____ AIDS - Date of AIDS Diagnosis: _____

 AIDS Diagnosis based on: _____

_____ Most Recent T-Cell Count: _____ Date: _____

_____ Most Recent Viral Load _____ Date: _____

_____ TB Test: Result: _____ Date: _____

OTHER PERTINENT INFORMATION:

Physician (Please Print)

Physician (Signature)

Phone

Date

MAP Office Use Only:

CM: _____

Date Mailed: _____

Received by: _____

Date Received: _____

This form 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.



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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