The Aliveness Project
Transportation Program Intake

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

____

First Name　　　Middle Name　　　Last Name

____

Address　　　County

____ ☐ YES ☐ NO

City　State　Zip code (*Required*)　OK to send Mail (*envelopes do NOT say "TAP"*) _____

________________________ ☐ YES ☐ 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)

When was your last visit to your HIV doctor/lab work?: Month/Day/Year of appointment: ____/_____/________

What was your viral load at that visit?___________________________________

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

Country of Birth: ☐ **USA** ☐ **Other: Specify**__________________ ☐ **Refused** ☐ **Unknown**

Date Client Moved to MN:_______________________________

****Required Eligibility Documentation** You must provide proof of Ryan White eligibility and Health Insurance. Please submit a copy of *AT A Glance* showing you are open and eligible to receive Ryan White Services. You may get a copy of your *At A Glance* from your HIV Provider or Transportation staff. Please submit a copy of MNITS showing whether you are enrolled in a Public Medical Assistance Program. You may get a copy of your MNITS from your HIV Provider or Transportation staff.**

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 The Aliveness Project. I also acknowledge that I have received a copy of The Aliveness Project HIV Services Programs Client Consent Form. I acknowledge that the information provided in this intake is true and I authorize The Aliveness Project to verify the accuracy of the information as necessary. I authorize The Aliveness Project to share my first name, phone number and necessary ride details with the taxi company that will provide my ride.

______________________________________　　　________________________

Signature　　　Date

Return by Fax to: (612) 341-3804

Or Mail to: The Aliveness Project
Attn: Transportation Program
3808 Nicollet Avenue
Minneapolis, MN 55409

The Aliveness Project
HIV Services Programs
Client Consent Form

Introduction
The Aliveness Project's client services programs are intended to support you. You are eligible to participate in the programs because you are an HIV infected person living in Minnesota and meet program eligibility criteria. This notice is given and/or reviewed with all The Aliveness Project clients. For the purposes of this document, clients are defined as those persons receiving reportable services including: AIDSLine services, case management, transportation, housing services, benefits counseling, Every Penny Counts Emergency Assistance, and other support services.

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

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

Information about you may be exchanged among The Aliveness Project 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.

Client Responsibilities
As a client at The Aliveness Project, it is important that you notify program staff of any changes in address and/or telephone number to achieve regular and effective communication. In addition, you may be asked to sign agreed-upon release of information forms so program staff can communicate with others as you work toward goals. If you choose not to give program staff consent to talk with others involved in your care, certain services may be affected. **Consent for your assigned program staff to communicate with other program staff at the Aliveness Project is automatic if you choose to receive services The Aliveness Project.**

Client Bill of Rights
Any member of The Aliveness Project is entitled to the following rights:

- The right to treatment with dignity and respect in a nonjudgmental manner, regardless of HIV status, race, ethnicity, religion, age, country of origin, sexual orientation, or sexual identification.
- The right to keep one's HIV status and other personal information confidential. Information will be withheld from all inquirers, including family member, friends, spouse/partner, medical providers, or law enforcement personnel except in cases of life-threatening situations, child abuse or with the written request/permission of the client.
- The right to full information about the services offered by The Aliveness Project.

- The right to refuse or discontinue services at any time for any reason. This includes the right to inspect all client-specific documents, including intake forms, assessment forms, case notes and any other documents pertaining to the client only.
- The right to information pertaining to the grievance and appeals process in the event that a member has a dispute with a staff person or service provider.
- The right to be protected from sexual, verbal and/or physical harassment from staff or other service providers of The Aliveness Project.
- The right to be protected from discharge from membership without due cause, notice and/or process.

Grievance Procedure
It is the policy of The Aliveness Project that services will be provided to all individuals without discrimination on the basis of HIV infection, race, creed, color, age, sex, gender, sexual orientation, religion, national origin, physical or mental disability, or any basis prohibited by law. You have the right to file a grievance if you feel you have been treated unfairly in any way. You will suffer no repercussions in service delivery solely as a result of filing a grievance. All grievances will be addressed in a confidential manner.

If you have a grievance or recommendation, you should first discuss it with the case manager or staff you are working with. If this is not successful or if you feel that this is not an option, you should proceed with the following steps:

1. A written statement should be prepared (including date and time of incident) of the grievance.
2. Submit the grievance to the Case Manager or staff supervisor. An appointment will be scheduled for you to meet with the supervisor to resolve your grievance.
3. If the matter cannot be mediated, your grievance may be referred to the Executive Director for final resolution.
4. Grievances will receive prompt attention. Every effort will be made by all appropriate staff to address and resolve grievances within ten (10) working days.

All written correspondence can be mailed to or dropped off at

- The Aliveness Project, 3808 Nicollet Ave, Minneapolis, MN 55409

Client's Statement
By signing below, I acknowledge that I have read and understand the above information and consent to receive services provided by The Aliveness Project under the conditions stated above. I agree with The Aliveness Project that programs require my active participation, cooperation, and coordination between my assigned program staff and my medical provider. I understand that if I do not actively participate and cooperate, The Aliveness Project program services will be discontinued. I can also voluntarily discontinue services, in writing, at any time.

I acknowledge that I have received copies of this consent form, the Bill of Rights and the HIPAA policy. Any and all copies of this document are to be considered as binding as the original.

________________________________ ________________
Client Signature Date

________________________________ ________________
Client Name (Please Print) Access Pass Number

________________________________ ________________
Program Staff Signature Date

The Aliveness Project

Transportation Program Payer of Last Resort Agreement

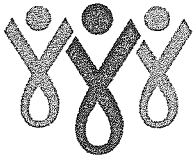
The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) has established the following policy for the use of Ryan White HIV/AIDS Treatment Extension Act of 2009 funds for medical transportation services:

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 The Aliveness Project's medical Transportation Services only when I have no other transportation services available.

Signed:

____	__________________________
Client Name	Date Signed



The Aliveness Project
Authorization for Release of Information

I__ ___ (Date of Birth) _ ___ authorize the written, verbal, and/or faxed exchange of information including but not limited to the following records for the purposes of continued care:

Requesting Agency: The Aliveness Project	**Provider/Clinic/Agency:**
Address: 3808 Nicollet Avenue, Minneapolis, MN 55409	**Address:**
Phone: 612-822-7946	**Phone:**
Fax: 612-822-9668	**Fax:**
Contact:	**Contact:**

I give permission with informed consent to The Aliveness Project and the individual/agencies listed to exchange the following requested information.

- ❑ Case Management
- ❑ Chemical Dependency
- ❑ Dates of Past HIV Medical Appointments
- ❑ Emergency Contact
- ❑ Financial Assistance
- ❑ HIV Verification
- ❑ Housing
- ❑ Laboratory Reports
- ❑ Medication List
- ❑ Mental Health Progress Notes
- ❑ Progress/Clinic Notes
- ❑ Other: ______________________________

All information regarding alcohol/drug use or abuse, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:

____Do Not Release Alcohol/Drug Use or Abuse records
____Do Not Release Mental Health Records
____Do Not Release HIV/AIDS records

I understand that this authorization is valid for one year. I understand that this form may not be released to any other organization without my written permission. I understand that such information may be used to determine eligibility of assistance. I know that I may cancel this authorization at any time in writing but that doing so may jeopardize my standing in the program if authorization is necessary to be in compliance with the program. Any cancellation does not apply to the information previously shared. I understand that such information may be used to determine eligibility of assistance.

A photocopy or facsimile of this authorization may be used in place of the original.

______________________________ __________
Individual's Signature Date

____
Staff Signature Date

The Aliveness Project Transportation Program
BUS CARD AGREEMENT

I am applying for a bus card at The Aliveness Project Transportation Program because I am not currently eligible for a bus card at any other agency or through case management. 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 The Aliveness Project'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