Every Penny Counts Emergency Assistance (EPC)
PO Box 582943
Minneapolis, MN 55458
(612) 331-7733 Metro Area
(800) 565-9028 Greater MN
(612) 341-3804 Fax
Email – EPC@aliveness.org

EPC Client # _____

PE Client # _____

(for office use only)
7/1/24 – 6/30/25
Prior forms no longer valid

See attached guidelines/eligibility criteria form.

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

Legal First Name | Middle Name | Last Name | (Preferred name)

Address | Apt # | County

☐ YES ☐ NO

City | State | Zip *(Required)* | OK to Send EPC Mail

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, SSDI, GA, etc): $_____

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

****Required Eligibility Documentation** You must provide proof of Ryan White eligibility.**
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 EPC staff.

Do you currently receive any form of housing subsidy? Yes ___ No ___
If you do receive a housing subsidy, what is your portion that you pay toward your rent?_____

Sexual Orientation (Select one):
☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Straight/heterosexual ☐ Other_____

When was your last HIV lab date?: (viral suppression data information is needed every 6 months)

Month/Day/Year of last lab date: _____ What was your last viral suppression data results:_____
If you're not in medical care please contact the MN AIDSLine at (612) 373-2437 for a physician referral.

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

What type of assistance are you seeking (circle all that apply):

Rent Utility/phone Medical/dental Food Vouchers

I attest that by signing this form that I am having a financial hardship, have no other resources available to me and not receiving this emergency financial and/or food voucher assistance will result in danger to my health and wellbeing.

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

_____ _____
Signature Date