Every Penny Counts Emergency Assistance for Housing Assistance in Greater Minnesota

Gr. MN client #_____
PE client # _____
For Office use

I am applying for: (check one)
☐ **Emergency rental assistance**
☐ **Emergency mortgage assistance**
☐ **Utility assistance**
Amount requested: $_____

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, 2nd 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:

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

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

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 Every Penny Counts Emergency Assistance (EPCEA) program 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.** An individual may access assistance up to 3 times with in a twelve month period. These 3 accesses can consist of just one request or it can be a combination of requests for rent, mortgage or utilities. If a client submits (example) a request for rent and utility assistance both in the same month and they are selected that is only considered 1 access. Following 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 1st 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 $1,000 is available for **one** month's rent within a 12 month period.
3. Assistance for rent can be provided for up to 2 additional months 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, however they do qualify for the utility assistance portion 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 $1,000.00 is available for **one** month's mortgage payment within a 12 month period.
3. Assistance for mortgage can be provided for up to 2 additional months 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 $400 with a 3 access limit 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. **Clients receiving any form of rental assistance do not qualify for rental assistance but do qualify for the utility assistance portion of the Gr. MN Housing Assistance program.**
5. Payment is made directly to the utility company.

PLEASE NOTE: You cannot be selected more than 3 times for assistance (more than 3 different months) from the lottery in a year for all assistance. If selected for 2 or more request within the same month, that counts as only 1 time of assistance, leaving them with 2 more times of 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 (1st 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 ever 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
Email – EPC@rainbowhealth.org

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.

Check 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: _____

No Income Statement

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

I**, _____** am receiving services from

_Rainbow 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.

AUTHORIZATION TO EXCHANGE INFORMATION

I hereby authorize _____ at Rainbow 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 Rainbow 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 Rainbow Health staff and trained volunteers.
I have been informed of my right to refuse to allow Rainbow 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.

Rainbow Health Client Bill of Rights

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

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

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

Rainbow Health
GRIEVANCE PROCEDURE

1. Any person receiving services from Rainbow 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 Rainbow 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 Rainbow Health.

4. Some programs offered by Rainbow 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.