Rainbow Health 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

☐ YES ☐ NO

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

☐ 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)

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.

- ☐ Copy of driver's license / MN State ID
- ☐ Current Utility Bill
- ☐ MN-ITS printout
- ☐ Current Lease agreement
- ☐ Read and sign a 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 documentated 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

If you're in the need of housing assistance please contact the MN AIDSLine at (612) 373-2437 for housing resources.

Race *(Select one or more)*:

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

If you're in the need for health insurance please contact the MN AIDSLine at (612) 373-2437 for insurance resources.

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 Rainbow Health. I also acknowledge that I have received a copy of the Rainbow 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 Rainbow Health to verify the accuracy of the information as necessary. I authorize Rainbow Health to share my first name, phone number and necessary ride details with the taxi company that will provide my ride.

_____ _____

Signature Date

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

Metro Area Transportation Program Guidelines

The Rainbow Health 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 providers as the Rainbow Health Transportation Program is the Payer of Last Resort. Please contact the Transportation Program for a complete list of current ride types available. Rides are scheduled on a first come, first served basis, based on fund 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;
  - The type of appointment the ride is for;
  - 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).

- Again, in order to arrange a taxi ride for you, we will need to share your first name, phone number and necessary ride details with the taxi company so that they can provide the ride for you to your appointment.

- 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. Taxis charge our program per minute of wait time, and taxis 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: Rainbow Health 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 cards 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. Cards are available by mail and are mailed within two weeks of the date they are requested. Contact Rainbow Health Transportation for more information.

To be eligible for the 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 or a MN-ITS printout showing program HH.
- 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 once a year.
- 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 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 showing proof of insurance. 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 Rainbow Health Transportation Program to be allowed to speak with their clinic, case manager, family member, partner or any other person about services. This form must be updated annually.
- The **"Rainbow Health 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 each year, to receive this service.

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

Here is a list of some of the ride types that the Rainbow Health 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, Food shelf, etc. Call the Transportation Program to find out what ride types are currently being offered – 612 373-2430.

Rainbow Health 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 Rainbow Health's medical Transportation Services only when I have no other transportation services available.

Signed:

_____ _____

Client Name Date Signed

Rainbow Health Transportation Program
BUS CARD AGREEMENT

I am applying for a bus card at Rainbow Health 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 Rainbow Health'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

This form is available in alternate formats

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.

Rainbow Health MN
2577 Territorial Road
St Paul, MN 55114

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 Rainbow Health and may result in my termination from them.

_____ _____

Client signature Date

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.

DATA PRACTICES NOTICE

This notice is given and/or reviewed with all Rainbow 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 Rainbow 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 Rainbow Health is, in nearly all cases, considered private data, which means you have access to it. Rainbow Health is aware of the sensitive and private nature of much of the information that is shared between clients and Rainbow Health staff. Rainbow Health as an agency, is committed to maintaining and protecting your confidentiality.

Why Rainbow Health Collects Data

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

Information about you may be exchanged among Rainbow 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 Rainbow Health staff. Generally this will not affect the services you are receiving. However, in some cases, there is the possibility that Rainbow Health will be unable to provide some type of service to you unless we have certain information. Rainbow Health staff will let you know if your refusal to share information will affect the services that can be provided.

Rainbow Health provides information to agencies and government offices that provide funding to Rainbow 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 Rainbow Health. The same law that gives you privacy prohibits these persons or entities from releasing information about you once they have received it.

Rainbow 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, Rainbow 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.

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.