CLEAR FORM

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@rainbowhealth.org

EPC Client # _____
PE Client # _____
(for office use only)
7/1/23 – 6/30/24
Prior forms no longer valid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 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): _____

You must provide documentation of proof of income for all family members who have income. We cannot provide services to you without documentation of your income.

Income verification is needed every 6 months. Place a check next to the option you have chosen below:

☐ **Option 1**
Attach documents showing proof of income such as a copy of: your most recent pay stub (within the last 60 days), a 2022 tax return, certification of zero income form or affidavit, a benefit statement such as a 2023 Social Security award letter, MFIP award letter, a bank statement showing deposit of income, etc.

☐ **Option 2:**
If you are on Medical Assistance (MA, IM), MinnesotaCare or Program HH you may send a copy of a MN-ITS printout indicating that you are on MA, MNCare or Program HH as income verification documentation. A copy of your MN Health Care Programs card does not qualify as income verification.

☐ **Option 3:**
Zero Income and I have completed and attached the Certification of Zero Income.

Living Situation: ☐ Stable/Permanent ☐ Temporary ☐ Unstable

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?_____

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

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, lease agreement, MN-ITS printout.

☐ Copy of driver's license / MN State I.D. ☐ Current Lease agreement ☐ MN-ITS printout
☐ Current Utility Bill ☐ Read and sign RH Residency Verification Form

Race (*Select one or more)*:

☐ White ☐ American Indian ☐ Alaska Native ☐ Asian
☐ African American/Black ☐ Native Hawaiian ☐ **P**acific Islander

Ethnicity (Select one)**:**

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Gender Assigned at Birth (Select one):

☐ Male ☐ Female

Current Gender Identity (Select one)**:**

☐ Male ☐ Female ☐ Transgender female ☐ Transgender male ☐ Nonbinary

Sexual Orientation (Select one):

☐ Lesbian/gay/queer ☐ Straight/heterosexual ☐ Bisexual ☐ Other _____

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 below if date is estimated ☐ Estimated date of HIV diagnosis

Date of AIDS Diagnosis_____ Month/Day/Year ☐ Estimated date of AIDS diagnosis

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.

Exposure Category: Select one or more

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

Health Insurance: Select one or more

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

If you have health insurance you must attach proof, such as a copy of your current insurance card, written notice of coverage, MN-ITS printout, 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 Minnesota: ☐ Yes ☐ No **If no, date you moved to Minnesota?** _____

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 ☐

If you were not selected for your request one month, do you want us to automatically resubmit your request for the next month's drawing? Yes☐ No☐ You will ONLY be submitted for the following month drawing. You will have to request to be resubmitted after that.

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 Rainbow Health. I also acknowledge 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.

_____ _____
Signature Date

2023-2024 Metro Area Guidelines (11 county TGA) for

Every Penny Counts Emergency Assistance (EPC)
PO Box 582943
Minneapolis MN 55458
epc@rainbowhealth.org

612-331-7733
1-800-565-9028 (Toll free)
612-341-3804 (Fax)

Every Penny Counts Emergency Assistance (EPC) program is available for low-income (see income guidelines), HIV-positive Minnesotans. Please read these guidelines carefully. **Failure to complete the application or provide correct documentation will result in a delay in meeting your emergency need**.

- **Emergency Financial Assistance (EFA) which includes rent, utilities, phone, Food Voucher Assistance and Medical/Dental assistance are all now at 400% FPG and below.**
- **There are three separate categories of funding. Clients have EFA funding out of one source of funding, Food Vouchers out of another source of funding and Medical/Dental out of another source of funding**
- **Rent assistance will be limited to 3 months of assistance per funding year or 3 accesses.**
- **Utility/phone assistance will be limited to 6 months of assistance per funding year or 6 accesses. May submit multiple utility bills for the same month and it will only count as 1 access.**

The 3 tier funding breakdown is as follows for Emergency Financial Assistance (EFA) rent, utilities, and phone:

Tier 1a: $500 limit per funding year – for clients regardless of household size receiving any kind of rent subsidy and pay $300 or less themselves toward rent. Must submit proof of current subsidy amount to receive rental assistance. Need actual amount client pays themself toward the rent.
Tier 1b: $700 limit per funding year – for clients regardless of household size receiving any kind of rent subsidy and pay $301 or more themselves toward rent. Must submit proof of current subsidy amount to receive rental assistance. Need actual amount client pays themself toward the rent.
Tier 2: $1,500 limit per funding year – for single clients, married clients or for families of up to 3 legal dependent members living together.
Tier 3: $2,000 limit per funding year – for families of 4 or more legal dependent members living together.

**Warning - Any applicant on a subsidy that does not share their subsidy status or any applicant who list more legal dependents than they truly have to receive a greater amount of funding may be suspended or expelled from Every Penny Counts Emergency Assistance program.

EFA-rent, utilities, and phone: Eligible individual whose income is at 400% FPG and below may receive assistance per program year (July 1 – June 30) for the following from EFA funding:

Rent: Applicants must provide a copy of lease or a completed shelter verification form, current subsidy recertification letter, or application fee. Only pay clients portion of the rent when on a subsidy or in a roommate type of situation. *Damage deposits, storage fees, mortgages, pet fees, GRH and foster care/nursing home fees/rents are not eligible for assistance*.
Moving fees: Applicants must provide an invoice for professional movers or U-haul truck rental only.
Utilities: Applicants can apply for fuel oil, propane, gas, electric, or water bill assistance. Applicants must submit a copy of bill/s. *Cannot pay for garbage fees.*
Phone: For bundled services, you must submit a copy of the entire bill. *Cable, internet, streaming services, Comcast/Xfininty bills, multiple phone lines, prepaid cards, prepaid phone plans and pay as you go phone plans are not eligible for assistance.*

EFA-Medical/Dental: Eligible individual whose income is at 400% FPG and below may receive up to $1,000 assistance per program year (July 1 – June 30) for medical. This is separate funding and does not come out of your total funding based on the Tier you are eligible for:

Medical care: Doctor, outpatient hospital visits, clinic visits, mental health visits, home health care, substance abuse care, dental care, dentures, chiropractic care, vision care (including glasses), prescription co-pays, medical co-pays, health insurance premiums and medical transportation bills (ambulance, special transportation services) that are not paid from health insurance or other eligible sources. If requesting dental assistance, must include a copy of dental insurance card along with dental bill. Clients who are on Program HH should see about prior authorization from Program HH. Dental bills will be forwarded to Program HH if client is on HH for possible payment, if HH is unable to pay the dental bill they will notify EPC and then EPC will assist with it. All medical and dental bills need to be submitted to insurance plan for payment prior to sending to EPC. *Any type of inpatient hospital bills and cosmetic surgery are not eligible for assistance.*

Food Vouchers: Eligible individual whose income is at 400% FPG and below may receive assistance per program year (July 1 – June 30) for Food Voucher funding. This is separate funding and does not comes out of your total funding based on the Tier you are eligible for:

Food: Food assistance is provided through Cub Foods gift cards. Individuals and families of up to three (3) dependents without a minor child can receive up to $60 per month for a max of $720 per funding year. Families of three (3) dependents or more with at least one (1) child can get up to $100 per month for a max of $1,200 per funding year. You may call to submit a request for food assistance for a specific month drawing, or request be submitted automatically for each monthly allotment drawing.

If you receive an official **eviction notice** (UD filing/letter from management company**)** and/or a **disconnection notice** before the next allotment drawing, you may submit a copy of the eviction or disconnection notice as well as a payment plan for immediate review and possible processing. Only one eviction or disconnection notice is allowed for immediate processing per client/family per funding year. After that any additional disconnection or eviction notices will be submitted into the regular allotment drawing process.

A complete application includes:

1. A completed **application form** (both sides) including your most recent **doctor's appointment date**. A new application must be completed for each program year (July 1 – June 30). If you request assistance more than once during the program year and have a current application on file, you do not need to complete another application for additional requests.
2. **Proof of the income** reported on the application. Eligible documents include copy of most recent paystub (within the last 30 - 60 days), 2022 tax return, benefit statement (2023 Social Security award letter, MFIP award letter), bank statement showing deposits, certification of zero income form or affidavit, a MN-ITS printout indicating you are on Medical Assistance (MA), MinnesotaCare or Program HH. A copy of your MN Health Care Programs card does not qualify as income verification.
3. **Proof of Residence** 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 without documentation.
4. **Proof of Medical Insurance** such as a copy of current insurance card, written notice of coverage, or MN-ITS printout showing insurance coverage.
5. **Proof of Dental Insurance** such as a copy of current insurance card, written notice of coverage, or MN-ITS if only on MA or MNCare.
6. A **copy of the bill** you want paid, and/or **a copy of your lease or a shelter verification** form completed by your landlord if requesting housing assistance or moving invoice.
7. **If this is the first time you are applying** for assistance, please provide written verification of your HIV-positive or AIDS status signed by a licensed health care professional or a MN-ITS printout indicating you are eligible for Program HH.

EPC must collect updated income verification, proof of residency, proof of medical insurance, lab appointment dates and viral suppression load results data from clients every six (6) months. EPC cannot provide assistance without current eligibility documentation.

Procedure

A drawing is conducted on the first business day of the month. Funds for emergency housing, utilities, medical and food assistance are divided evenly by month so that the same total of funding is available each month. Once the allotted monthly funding has been spent on individual requests, no further assistance will be available until the following month. All requests that meet necessary requirements will be submitted to the drawing. **Requests must be submitted by noon of the prior business day of the allotment drawing.** Requests for assistance will **not** automatically be carried over to the next month (except for monthly food allotment requests). If your request was not selected, you must resubmit your request to be considered for the following month's drawing or check the yes question on the application to have your request be automatically resubmitted into the next drawing.

Requests for assistance must be for **$20.00 or more**. Requests for less than $20.00 will not be processed (exception is for prescription co-pays, medical insurance premiums & medical co-pays).

Every Penny Counts makes assistance payments directly to the vendor. We will contact you by mail if your request **will not** be paid. EPC cannot reimburse a client for any out of pocket expenses.

To qualify for assistance, applicants must meet all eligibility requirements. **This service is funded by the federal Ryan White HIV/AIDS Treatment Modernization Act, Part B or Part B Rebate and as such is the Payer of Last Resort, so clients must have used any other available funding resources prior to accessing Every Penny Counts**

Clients will not be allowed to request that they be submitted until their funds are exhausted for EFA assistance.

PLEASE NOTE:

Please call our voicemail and leave a detailed message if you have questions. We will usually return your call within one (1) working business day. It can take up to five (5) business days (not including the actual drawing day) to process your request if it is selected and mail out checks. The EPC voice mail greeting is updated after each drawing to reflect program's status, funding availability, and the next drawing date. Due to holidays, drawing dates may be changed accordingly and noted on the EPC voicemail.

Food requests selected in the drawing will usually be mailed out around the 20th of each month, any changes to this date will be included on the outgoing EPC voicemail.

During the grant period/year, program guidelines and the amount of funding allowed individuals is subject to change based on needs and/or the availability of funding. In the event of a program change, a notice will be sent to providers and the EPC voicemail will be updated.

EPC has a grievance policy. Contact the Minnesota AIDSLine (612-373-2437) for further information.

INCOME GUIDELINES FOR EVERY PENNY COUNTS EMERGENCY ASSISTANCE
(effective July 1, 2023)

2023 Federal Poverty Guidelines (400%)

Family Size	Gross Annual Income	Gross Monthly
1	$58,320	$4,860
2	$78,880	$6,573
3	$99,440	$8,287
4	$120,000	$10,000
5	$140,560	$11,713
6	$161,120	$13,427
7	$181,680	$15,140
8	$202,240	$16,853

For family units with more than eight members, add $20,560 for each additional member to annual income. "Family Unit" is defined as all people living together that are **legally dependent** on the income. Income for all members of the "family unit" will be considered for these guidelines and must be submitted with application.

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.

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 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

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.

To Be Completed by Owner, Manager, or Caretaker Only

(Complete all appropriate information and mail or fax to agency address/fax number on first page.)

Note: Completing this form does not guarantee rent payment.

TENANT NAME	PHONE

STREET ADDRESS	STATE	ZIP CODE

Rental Information

Date moved in _____ Number of adults in unit _____ Number of children in unit _____

Total rent for unit $_____ Damage deposit $_____ ☐ Paid ☐ Not paid

Amount of rent **paid by tenant** $_____ per ☐ Week ☐ Month ☐ Other Effective date _____

Is any portion of the rent **paid by rental subsidy**? ☐ Yes ☐ No

If yes, is the subsidy from Public Housing, HUD project properties or Section 8? ☐ Yes ☐ No Amount $_____

Is any portion of the rent **paid by GRH**? ☐ Yes ☐ No

Check (x) which utilities the **tenant** is responsible to pay:

☐ Gas ☐ Electricity ☐ Garbage removal ☐ Water and sewer ☐ Air conditioning ☐ Garage/plug-in

Is Garage or plug-in optional? ☐ Yes ☐ No Amount $_____

☐ Other _____

☐ None

MANAGEMENT COMPANY [whose checks should be made to]	DAYTIME PHONE NUMBER			
STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE
NAME OF OWNER/MANAGER/CARETAKER COMPLETING FORM (Please print)	TITLE	PHONE NUMBER		

I hereby certify that the information above is complete, true and correct.

SIGNATURE OF OWNER/MANAGER/CARETAKER COMPLETING FORM	DATE