



Holiday Basket Application

Deadline: 3:00 p.m., Friday, November 7, 2014



Today's Date: _____

PLEASE PRINT!

This Box for Office Use Only

1. APPLICANT:

Your Aliveness Project ACCESS PASS:

Basket # _____

☐ Greater MN SHIPPING

Name: _____
First Name M.I. Last Name

Street Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Daytime Phone: (_____) _____ E-mail: _____

Date of Birth: ____/____/____ Race(s): _____

2. SPOUSE / PARTNER:

Note: Spouse/Partner must live with applicant.

Date of Birth: ____/____/____ Race(s): _____

Is your spouse/partner a member? ☐ Yes ☐ No If yes - ACCESS PASS:

3. CHILDREN: Do you have children who live in your household? ☐ Yes ☐ No

NOTE: Only CHILDREN OF APPLICANT who live in same household are eligible (age limit: 18 years).

1st Child: _____ Date of Birth: ____/____/____ Race(s): _____
First M.I. Last

2nd Child: _____ Date of Birth: ____/____/____ Race(s): _____
First M.I. Last

3rd Child: _____ Date of Birth: ____/____/____ Race(s): _____
First M.I. Last

FOR ADDITIONAL CHILDREN, PLEASE ATTACH SHEET WITH INFORMATION FOR EACH CHILD.

4. TYPE OF BASKET & PICK-UP or DELIVERY DATE (please check ONLY ONE):

HOLIDAY BASKET (for Christmas or another year-end holiday):

☐ I will PICK UP my basket on Dec. 19 or 22 (Friday or Monday), between Noon - 7 p.m.
(No pick up on weekend.)

☐ Please DELIVER my basket on Wednesday, December 24, between 9 a.m. - 3 p.m.

HANUKKAH BASKET (for people of Jewish faith/background):

☐ I will PICK UP my basket on Tues., Dec. 16 ☐ Please DELIVER my basket on Tues., Dec. 16

5. CASE MANAGER:

Case Manager: _____ Phone: (_____) _____

If we have questions about your application, may we contact your case manager? ☐ Yes ☐ No

6. SIGNATURE: I confirm that my information is true & accurate. If children are included in this application, I give permission to release my name, address & number of children to Toys for Tots to process toy requests for this year.

_____ (Applicant Signature)



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This page serves as a guide for preparing your Holiday Basket.

Note: Your gift suggestions are helpful,
but are not a guarantee of what you actually may receive.

SIZES: *Please be as specific as possible:*

- For each person, list exact size – such as XS, XXL, 2T, etc.
- For women, please note Juniors, Miss, or Mrs.
- For teenagers or pre-teens, please specify child or adult sizing.
- For men, please include waist & length for pants (W32" x L34")
- Please note style of clothing: "youthful," "mature," etc.

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Basket # _____

☐ **ADOPTED**

Note: _____

☐ **TO SHIP / Greater MN**

☐ **Completed:** _____

PLEASE PRINT!

YOURSELF: Gender _____ Age _____ Race(s) _____ Height ____' ____"
Shirt _____ Style _____ Winter Clothing _____
Pants _____ Shoe _____ Hobbies/Other Requests _____

Spouse/Partner: Gender _____ Age _____ Race(s) _____ Height ____' ____"
Shirt _____ Style _____ Winter Clothing _____
Pants _____ Shoe _____ Hobbies/Other Requests _____

NOTE: Only CHILDREN OF APPLICANT who live in same household are eligible (age limit: 18 years)

1st Child: Gender _____ Age _____ Race(s) _____ Height ____' ____"
Shirt _____ Style _____ Winter Clothing _____
Pants _____ Shoe _____ Hobbies/Other Requests _____

2nd Child: Gender _____ Age _____ Race(s) _____ Height ____' ____"
Shirt _____ Style _____ Winter Clothing _____
Pants _____ Shoe _____ Hobbies/Other Requests _____

3rd Child: Gender _____ Age _____ Race(s) _____ Height ____' ____"
Shirt _____ Style _____ Winter Clothing _____
Pants _____ Shoe _____ Hobbies/Other Requests _____

Please attach additional sheet, if necessary.

I **HAVE A:** ☐ CD Player ☐ MP3 Player ☐ Computer ☐ Game Console: Type of System _____

List music styles or artists: _____

List book or movie titles: _____

Small household items: _____

Other special requests: _____

Applications are due in our office by **3:00 p.m. on Friday, Nov. 7.**

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HOLIDAY BASKET PROGRAM, The Aliveness Project, 3808 Nicollet Avenue, Minneapolis, MN 55409 FAX: 612-822-9668



Proof of Income Eligibility & Update Form



In order to be eligible for services funded by government grants we receive, **ALL RECIPIENTS OF FUNDED SERVICES** must have annual incomes at or below 300% of the Federal Poverty Guidelines, as listed below:

| Please Check | Household Size | Income Level (300% FPG) |
|--------------|----------------|-------------------------|
| | 1 | \$35,010 |
| | 2 | \$47,190 |
| | 3 | \$59,370 |
| | 4 | \$71,550 |
| | 5 | \$83,730 |
| | 6 | \$95,910 |
| | 7 | \$108,090 |

NOTE: You will not be denied a holiday basket or any services even if your income exceeds these guidelines. Our services are available to anyone living with HIV/AIDS. We must collect this information as a requirement of government grants we receive for specific programs.

Name: _____

Address: _____

Phone: _____ Access Pass Number: _____

INCOME STATEMENT:

My monthly income is: \$ _____ X 12 = \$ _____ (annual income)

- ☐ Attached is proof of income in the form of: _____
(Pay stub, Social Security determination letter etc.)
- ☐ My annual income exceeds these guidelines (no proof of income required).
- ☐ I have no personal income (\$0.00). I receive support through: (check all that apply)
- ☐ One or more of my family members are working or own a business.
 - ☐ One or more of my family members receives child support, SSI, SSDI, pension, etc.
 - ☐ 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 money in a savings, checking, trust fund account or proceeds of sale of personal items.
 - ☐ Another source (please explain): _____

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.

Your Signature: _____ Date: _____

Aliveness Staff Signature: _____ Date: _____

Note : If needed, you may be contacted by one of our staff regarding proof of residence or income.

MEDICAL INFORMATION UPDATE (Our grants ask us to collect this information, too):

- ☐ The date of my last HIV/AIDS medical appointment was: _____
- ☐ Do you have health insurance? ☐ Yes ☐ No If Yes, please check type:
- ☐ Private ☐ Medicare ☐ Medicaid /MA ☐ Other Public ☐ Other: _____

Do you have diet-related needs (such as diabetes, high cholesterol, drug side effects, etc.)? ☐ Yes ☐ No
If so, would you like our dietitian to contact you to talk about this? ☐ Yes ☐ No



Membership Policies



HIPAA Policy/Client Confidentiality: The Aliveness Project will maintain your personal and demographic information in a confidential manner. Access to information about the services you receive will be limited to Aliveness Project staff and to others for whom you have provided written consent to share or discuss your information. This information will also be maintained in a confidential manner. You will not be identified or identifiable in any written reports or publications without your written consent.

By agreeing to participate in programs at The Aliveness Project, you agree to provide information at the time of enrollment and periodically thereafter that will assist in data collection, assessment, and funding for services. For these purposes, personally-identifiable information will be provided to the Minnesota Department of Health (MDH) in accordance with contract agreements; however, The Aliveness Project and MDH will maintain your confidentiality as outlined below at all times. The goal of this is to make it easier for you to access additional services. The Minnesota Department of Human Services (DHS) and Hennepin County Ryan White Program will receive aggregate or group data only. The HIV/AIDS Bureau of the U.S. Department of Health and Human Services Health Resource and Service Administration (HRSA) does receive encrypted client level data that does not identify you by name or include any other identifying personal information. The data collected and reported to our funders is used to identify the services that individuals living with HIV/AIDS need and use, identify barriers to those services and unmet needs, and evaluate future funding needs.

The Aliveness Project may also be required by state laws and regulations to release information about you in the following circumstances:

- If there is a subpoena or a court order mandating us to release your records for use in a court proceeding.
- If you are threatening to harm another person and you have stated both the identity of the person and the means by which you plan to harm that individual.
- If you are threatening to seriously harm yourself and have identified a means by which you plan to do so.
- If you are threatening to commit a serious crime or are suspected of committing a serious crime.
- If it is suspected that you are being maltreated by a caregiver or are not able to protect yourself from maltreatment.
- If there is a reason to believe you are abusing or neglecting a child or vulnerable adult.

Client Bill of Rights: Any client/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, gender, religion, age, country of origin, sexual orientation, or physical/mental disability.
- The right to keep one's HIV status and other personal information confidential. Information will be withheld from all inquirers, including family members, spouse/partner, friends, medical providers, or law enforcement personnel except in cases of life-threatening situations, child abuse, or with the written request of the client.
- The right to receive services whether or not a member is currently receiving medical care for HIV/AIDS.
- 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 of The Aliveness Project.
- The right to be protected from sexual, verbal and/or physical harassment from staff or other service providers.
- The right to be protected from discharge from membership without due cause, notice and/or process.
- The right to receive to receive interpretation/translation services (for clients with limited English proficiency or hearing impairment), if no staff speaks the client's language or the client has not arranged for an interpreter.

Non-discrimination Policy: It is the policy of The Aliveness Project that services will be provided to all individuals without discrimination on the basis of HIV status, race, religion, color, age, sex, gender, sexual orientation, religion, national origin, physical or mental disability, or any basis prohibited by law.

Grievance Policy: 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. Here is the suggested procedure for filing a grievance:

1. If you have a grievance, you should first discuss it with the staff person with whom you are working. If this is not successful or if you feel that this is not an option, you should proceed with the following steps:
2. A written statement may be prepared (including date and time of incident.) Submit the grievance to the person's supervisor. If you prefer, a grievance may be communicated verbally.
3. An appointment will be scheduled for you to meet with the supervisor to resolve your grievance. 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 to address and resolve grievances within ten (10) business days. Written correspondence can be mailed or delivered to: 3808 Nicollet Avenue, Minneapolis, MN 55409.

Client's Consent for Services: I acknowledge that I have read and understand the above information and agree to receive services provided by The Aliveness Project under the conditions stated above. I may, without consequence, withdraw my participation from this organization's services at any time. I may request and receive a copy of this signed consent form at any time. Any and all copies of this document are to be considered as binding as the original.

Name (Printed)

Access Pass Number

Signature

Date