MEMBERSHIP APPLICATION

#_____
Date: _____
Staff: _____

Applicant's Name: _____
First Name Middle Name Last Name

Address: _____
Street Apt. County

_____
City State Zip Code

Telephone: (H)_____ (Cell) _____

(W)_____

E-mail: _____

May we contact you by telephone? ❑ **Yes** ❑ **No**

Is it OK for us to send mail to you? ❑ **Yes** ❑ **No**

Do you want to receive *The Aliveline*, our quarterly newsletter? ❑ **Yes** ❑ **No**

Do you want to receive our e-newsletter? ❑ **Yes** ❑ **No**

I am applying for:

❑ **Membership:** Aliveness Project Membership is open to any individual who is living with HIV/AIDS. There is no fee for full membership. **ONLY MEMBERS ARE ELIGIBLE FOR FREE SERVICES PROVIDED BY THE ALIVENESS PROJECT.**

MEMBERSHIP REQUIREMENTS

The Aliveness Project is a nonprofit organization with services provided by volunteers and staff. All services are free to members. Members may bring guests to group events, however members are responsible for their guests and must accompany their guests at all times. People who use services provided by The Aliveness Project do so by choice and with the understanding that The Aliveness Project and its volunteers assume no liability whatsoever in conjunction with any of these services and programs.

Members and guests are expected to adhere to the following guidelines: Membership and membership services are a privilege. We expect members to behave in an appropriate manner while at The Aliveness Project. This includes not engaging in profanity; shouting; verbal abuse or physical threats made towards others; violent, lewd or lascivious behavior; theft of and/or damage to equipment, personal property, or other parts of the building. Our guidelines also prohibit breaching confidentiality by revealing the HIV status of members or names of people seen at The Aliveness Project. Members are expected to keep and be on time for appointments. We understand that emergencies sometimes occur. However, members who violate these guidelines are subject to suspension of their membership or privileges for 30 days or longer. Members are expected to show respect to everyone in the building.

Removal of Membership: Suspension of more than thirty (30) days is deemed for removal of membership. Removal requires a two-thirds vote of the current Membership Advisory Committee (MAC). After removal, a member may reapply for membership after one year. A two-thirds vote by the MAC will be required to regain membership.

I have read and understand the membership requirements and privileges as stated above. Accordingly, I certify that I am eligible for the type of The Aliveness Project membership indicated above.

Signature of Applicant: _____ **Date:** _____

MEMBERSHIP APPLICATION

GENERAL DATA

Date of Birth: _____/_____/_____ (Month/Day/Year) **Current Age**: _____

Gender: ❑Male ❑Female ❑Transgender: Male to Female ❑ Transgender: Female to Male

Race: ❑**Am. Indian / Native Am.** ❑**Caucasian/White** ❑**African American/Black** ❑**African (born)**

❑**Asian:** ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Other Asian

❑**Pacific Islander:** ❑Native Hawaiian ❑Guamanian/Chamorro ❑Samoan ❑Other Pacific

Ethnicity: ❑**Hispanic/Latino** ❑**Not Hispanic/Latino**

If Hispanic/Latino, designate subgroup ❑Mexican ❑Puerto Rican ❑Cuban ❑Other Hispanic

Country of Birth: ❑United States ❑Other:_____

Date Moved to Minnesota:_____/____/_____ (Month/Day/Year) ❑**Born in Minnesota**

When were you diagnosed with HIV infection? ____/____/_____ (Month/Day/Year)

HIV Status: ❑**HIV Positive**
- ❑ I do not have an AIDS diagnosis.
- ❑ I have an AIDS diagnosis: Date of diagnosis: ___/____/_____ (Month/Day/Year)
- ❑ I do not know if I have an AIDS diagnosis.
- ❑ Pending / Indeterminate (infants only).

❑**HIV-Negative**

Does agency have documentation of HIV status?
❑No
❑Yes: Med. Record / Lab Report
❑Yes: MD / Medical Provider

HIV Exposure Category: **(check all that apply)**
❑Male to Male Sex ❑Heterosexual Sex ❑Injecting Drug Use (IDU)
❑Blood Recipient ❑Hemophilia ❑Perinatal (Mother to Child)
❑Occupational ❑Unknown

Do You Have Health Insurance? ❑Yes ❑No ❑Pending Verification Date:_____/_____/_____ (Month/Day/Year)

If Yes, Check Type of Primary Medical Insurance:
❑Medicare (Unspecified) ❑Medicare (A/B) ❑Medicare (D) ❑Medicaid (MA in MN, CHIP or other public)
❑Private – Employer ❑Private – Individual ❑VA,Tricare, Other Military Health Care
❑Indian Health Services ❑None

Have You Seen an HIV/AIDS Medical Provider in the Last 6 months? ❑No ❑Yes

Date of Last Appointment: _____

FOR STAFF: Was Referral Made? ❑No ❑Yes -Date of Referral: _____ Date of Follow-up: _____

MEMBERSHIP APPLICATION

PLEASE COMPLETE THIS FORM ONCE EVERY 6 MONTHS.

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% FPL)
	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 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 from sale of personal items.
- ☐ Another source (please explain): _____.

MOST RECENT MEDICAL APPOINTMENT (Our grants ask us to collect this information, too):

☐ **The date of my last HIV/AIDS medical appointment was:** _____

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**

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:** _____

MEMBERSHIP APPLICATION

HOUSING

Living / Housing Situation: ❑Stable / Permanent Housing (e.g., rental, home-owner)
❑Temporary (with friends/ relatives, treatment facility, transitional housing)
❑Unstable (homeless)

HOUSEHOLD MEMBERS

Number of children living with you at least 20 hours per week: _____

Total number of people in your household: _____

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

SPOUSE / PARTNER: _____

First Name *Middle Name* *Last Name*

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

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

CHILDREN:

Please complete the following information for each child (use additional pages if needed):

First & Last Name of Child	Date of Birth	Age	Gender	Race(s)

MEMBERSHIP APPLICATION

CONTACTS IN CASE OF EMERGENCY

Due to the confidentiality policy of The Aliveness Project, this information will only be used in case of emergency.

Emergency Contact: _____

Relationship: _____

Telephone: _____

Address: _____

_____

Is your Emergency Contact aware of your HIV/AIDS status? ❑ Yes ❑ No

Case Manager: _____

Agency: _____

Telephone: _____

Physician: _____

Clinic: _____

Telephone: _____

I, (please print) _____authorize The Aliveness Project to contact the emergency contact, case manager, and/or physician listed above.

Signature: _____ Date: _____

How did you hear about The Aliveness Project?

❑Case Manager ❑Doctor ❑Support Group ❑Friend/Family ❑AIDSLine

❑Newspaper ❑Magazine ❑Radio ❑TV ❑Health Fair/Festival/Concert

❑E-mail ❑Website: _____

❑Other: _____

MEMBERSHIP APPLICATION

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.

New Hires / Case Management Clients

To clarify boundaries in a social service organization, **The Aliveness Project will follow the "Best Practices" standard when hiring personnel to be case managers or other service providers that work with confidential, data-sensitive information.** Members who were or currently are case managed by an Aliveness Project medical case manager, work with prevention and harm reduction, or the nutritionist cannot become employees. Employees that stop being employees or even while employed, cannot be case managed or receive other services in a data-sensitive category at The Aliveness Project. This extends to any current employee who has access to the Personal Medical Information of other clients. Anyone already in a dual-role position at the date this policy was enacted **(03/27/2014)** will be exempt from this new policy,

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. 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:

1. A written statement may be prepared (including date and time of incident) of the grievance. If you prefer, a grievance may be communicated verbally.
2. Submit the grievance to the staff person's supervisor. 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.
3. 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, Mpls., 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.

_____ _____

Signature **Date**

Member Guidelines

The staff and volunteers of The Aliveness Project would like to welcome you and to insure your safety as well as enjoyment while attending programs and services, we have established several guidelines. The purpose of these guidelines are required and expected of all members and volunteers.

1. **The consumption of, distribution of, or being under the influence of alcohol or illegal substances while attending on/off-site activities is prohibited.**
2. **Verbal abuse, sexual harassment or physical threats directed towards staff, volunteers or other members under any circumstances are not permitted. Racial or discriminatory slurs or insults are not allowed.**
3. **No guns or any type of weapons are permitted within our facility.**
4. **Smoking is not permitted anywhere within our building. E-cigarettes are also not allowed within our facility.**
5. **According to health code standards, only staff and authorized volunteers are permitted in the kitchen areas.**
6. **The removal of items (including food, salt and pepper shakers, books, furnishings or other property) without consent of the staff is prohibited.**
7. **No animals of any kind are permitted in the dining room at The Aliveness Project; with the exception of seeing-eye dogs (prior notice is required).**
8. **Misrepresenting oneself as a member of The Aliveness Project staff is prohibited.**
9. **Program services and the Access Pass Business Listing are limited to use by members only.**
10. **It is not the sole responsibility of staff or volunteers to maintain cleanliness of the center. It is expected that members will clean up after themselves after meals and other activities.**
11. **No sleeping or food consumption will be allowed in the lobby. If you need to lie down, please see a staff member about using a therapy room.**
12. **When accessing services, members are expected to comply with all program rules.**
13. **Members are also expected to keep appointments and arrive on time. We understand that emergencies sometimes occur. However, failure to give adequate notice regarding missed appointments may result in a 30-day suspension of a member's privilege to access that service.**

Membership and access to services at The Aliveness Project are a privilege. We expect members, staff and volunteers to behave in an appropriate manner while in our building.

Members who violate these guidelines are subject to having their membership suspended for 30 days or more. Any Aliveness Project employees who violate these guidelines may be subject to suspension without pay or immediate dismissal.

The Aliveness Project's staff and Board of Directors reserve the right to amend these guidelines when necessary. Members have the right to expect that the changes will appear in the newsletter. Failure to comply with these guidelines can result in suspension from The Aliveness Project.

MEMBERSHIP APPLICATION

VERIFICATION OF ELIGIBILITY FOR MEMBERSHIP

MEMBERSHIP APPLICANT:

I _____ _____
Name of Applicant (Please Print Full Name) Date of Birth

authorize_____
Name of Physician or Case Manager (Please Print)

to verify or disclose information that confirms I am HIV infected to The Aliveness Project.

_____ _____
Applicant's Signature Date

This verification form is valid for 90 days from the date of signature.

PHYSICIAN / CASE MANAGER:

This form is solely to establish eligilibity of the applicant to become a member of, and to receive services provided by The Aliveness Project. According to the Bylaws of The Aliveness Project, the only requirement for membership is that an individual is HIV-infected.

This information will be kept in confidential files along with the applicant's signed membership form. Thank you for your help in this matter.

I verify that _____ _____
Name of Applicant (Please Print) Date of Birth

is HIV-infected and is, therefore, eligible to become a member of The Aliveness Project.

_____ _____
Signature of Physician or Case Manager Date

Date of last medical appointment was: _____

Date viral load/CD4 was verified: _____

Clinic / Agency: _____

Office Address: _____

Telephone: _____ Fax: _____

Please fax or mail this form (to the address listed below) to:

Director of Member Services, The Aliveness Project FAX: 612-822-9668

Questions about this form? Please contact our Member Services Director at 612-822-7946.