the Aliveness project

Membership Application

THIS BOX FOR OFFICE USE ONLY
#_____
Date:_____Staff: _____

APPLICANT

Name:_____
First Name M.I. Last Name

Address: _____ Apt#:_____County: _____

City, ST, ZIP: _____ Phone: _____

Email: _____

May we contact you by phone?	❍ Yes ❍ No
Is it ok to leave a message?	❍ Yes ❍ No
Is it ok for us to text you?	❍ Yes ❍ No
Is it ok for us to send mail to you?	❍ Yes ❍ No
Is it ok for us to send you email?	❍ Yes ❍ No
Do you want to receive our e-newsletter?	❍ Yes ❍ No
Would you like to be introduced to other Aliveness Project Members?	❍ Yes ❍ No

I AM APPLYING FOR MEMBERSHIP

☐ **Membership:** Aliveness Project Membership is open to any individual who is living with HIV/AIDS. There is no fee for membership. **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. **The only requirement for membership is that an individual has HIV.** 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 in conjunction with services and programs.

Members and guests are expected to adhere to the following guidelines: Membership and 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 grounds for removal. 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.

SIGNATURE

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

Applicant Signature: _____ **Date:** _____

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GENERAL DATA

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

Gender: ☐ Male ☐ Female ☐ Transgender: Male to Female ☐ Transgender: Female to Male ☐ Other

Preferred Pronouns: check all that apply ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other _____

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: _____

Minnesota Native: ☐ Born in Minnesota ☐ Date Moved to Minnesota: _____ /_____/_____ (Month/Day/Year)

HIV INFORMATION

When were you diagnosed with HIV?

_____ /_____/_____ (Month/Day/Year)

HIV Status:
(check all that apply)

☐ 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

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

MEDICAL INFORMATION UPDATE

Required for Federal Funding

Date of my last HIV/AIDS medical appointment was: _____

Do you have **health insurance**?

☐ Yes ☐ No ☐ Pending

Verification Date ____ /____/_____ (Month/Day/Year)

If Yes, please check type:

❍ 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

FOR AGENCY USE ONLY:

Does agency have documentation of HIV status?

☐ No

☐ Yes: ❍ Med. Record/Lab Report ❍ MD/Medical Provider

Was Referral Made? ☐ No ☐ Yes

Date of Referral: _____ Date of Follow-up: _____

☐ Applicant eligible ☐ Applicant **not** eligible

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Proof of Income Eligibility & Update Form

PLEASE COMPLETE THIS FORM ONCE **EVERY 6 MONTHS**

Name: _____

Address: _____ Apt #: _____ City, ST, ZIP: _____

Access Pass Number: _____ Phone: _____

Email: _____

INCOME STATEMENT

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

Do you meet Federal Poverty Guidelines?

☐ **Yes** (check household size)

Household Size	Income Level (400% FPL)
❍ 1	$48,240
❍ 2	$64,690
❍ 3	$81,680
❍ 4	$98,400
❍ 5	$115,120
❍ 6	$131,840

☐ **No** - my annual income exceeds 400% FPL

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 400% of the Federal Poverty Level, as listed above.
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.

☐ Attached is **proof of income** in the form of:
- ❍ Pay stub
- ❍ Social Security determination letter
- ❍ Other (specify) _____

☐ My annual **income exceeds** Federal Poverty 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): _____

HOUSING STATUS

☐ **Stable / Permanent** (e.g., rental, home-owner)

☐ **Unstable** (homeless)

☐ **Temporary** (with friends/ relatives, treatment facility, transitional housing)

MEDICAL INFORMATION UPDATE

Required for Federal Funding

Date of my last HIV/AIDS medical appointment was: _____

Do you have **health insurance**?

☐ Yes ☐ No If Yes, please check type:
- ❍ 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

NUTRITION

Do you have **diet-related needs** (such as diabetes, high cholesterol, drug side effects, etc.)?

☐ Yes ☐ No

If yes, 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: _____

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HOUSING STATUS

☐ **Stable / Permanent** (e.g., rental, home-owner)

☐ **Temporary** (with friends/ relatives, treatment facility, transitional housing)

☐ **Unstable** (homeless)

HOUSEHOLD MEMBERS

Number of **children** living with you: _____

Total number of **people** in your household: _____

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

SPOUSE/PARTNER

note: spouse/partner must live with applicant

Name: _____
First Name Middle Name Last Name

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

Race(s): _____

Is your spouse/partner a member? ☐Yes ☐No If yes, Access Pass Number: _____

CHILDREN

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

1st Child: _____ Age: _____ Gender: _____
First Name Last Name
Date of Birth: _____ /_____/_____ (Month/Day/Year) Race(s): _____

2nd Child: _____ Age: _____ Gender: _____
First Name Last Name
Date of Birth: _____ /_____/_____ (Month/Day/Year) Race(s): _____

3rd Child: _____ Age: _____ Gender: _____
First Name Last Name
Date of Birth: _____ /_____/_____ (Month/Day/Year) Race(s): _____

4th Child: _____ Age: _____ Gender: _____
First Name Last Name
Date of Birth: _____ /_____/_____ (Month/Day/Year) Race(s): _____

5th Child: _____ Age: _____ Gender: _____
First Name Last Name
Date of Birth: _____ /_____/_____ (Month/Day/Year) Race(s): _____

6th Child: _____ Age: _____ Gender: _____
First Name Last Name
Date of Birth: _____ /_____/_____ (Month/Day/Year) Race(s): _____

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CONTACTS IN CASE OF EMERGENCY

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

Please list any allergies or other medical conditions we should be aware of:_____

_____

Emergency Contact: _____

Relationship: _____ Phone: _____

Address: _____

_____

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

Case Manager: _____

Agency: _____

Phone: _____

Physician: _____

Clinic: _____

Phone: _____

PERMISSIONS

I would like to give my permission for The Aliveness Project to post information regarding any hospitalization stays.

☐ **Yes**, I authorize The Aliveness Project to post information to receive community support.

☐ **No**, please do not post any information about me. I will not be denied any services.

I would like to give my permission if I pass for other members to be notified.

☐ **Yes**, I authorize The Aliveness Project to post information.

☐ **No**, please do not post any information about me. I will not be denied any services.

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

Your Signature: _____Date:_____

HOW DID YOU HEAR about The Aliveness Project?

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

☐ Newspaper ☐ Magazine ☐ Radio ☐ TV ☐ E-mail

☐ Health Fair/Festival/Concert ☐ Website: ☐ Other: _____

Member Policies

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. **Consent for Aliveness Project staff to communicate with other Aliveness Project staff is automatic if you choose to become a member at The Aliveness Project.**

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

The Aliveness Project will follow the "Best Practices" when hiring personnel to be case managers or other service providers that work with confidential, data-sensitive information. Members who were or are currently case managed by an Aliveness Project medical case manager, work with outreach and prevention, or the nutritionist cannot become employees of those programs prior to at least 1 year separation from those services or, at the discretion of the Executive Director. Current members that are employees cannot be case managed or receive other services in a data-sensitive category at The Aliveness Project or have 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 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 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 _____

Membership Application

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 disruptive 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. Viewing sexually explicit material on Aliveness computers or in the center, including pornographic websites or movies with sexually explicit content, is prohibited and will result in suspension from computer use.
4. No guns or any type of weapons are permitted within our facility.
5. Smoking is not permitted anywhere within our building. E-cigarettes are also not allowed within our facility.
6. According to health code standards, only staff and authorized volunteers are permitted in the kitchen areas. Shoes must be worn throughout the building. “No shirt, no shoes, no service.”
7. The removal of items (including food, salt and pepper shakers, books, furnishings or other property) without consent of the staff is prohibited.
8. No animals of any kind are permitted in the dining room, with the exception of service animals. Reasonable accommodation can be discussed with the Member Services Coordinator.
9. Misrepresenting oneself as a member of The Aliveness Project staff is prohibited.
10. Personal items may not be left or stored at Aliveness. Unclaimed items will go on the free table after 3 days.
11. Program services and the Access Pass Business Listing are limited to use by members only.
12. 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.
13. Sleeping is only permitted in lobby chairs; not at computers or in the dining room. No food consumption is allowed in the lobby.
14. When accessing services, members are expected to comply with all program rules.
15. 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.
16. Members who sign up for events are expected to attend or give notice that they will miss. Failure to give notice may result in suspension from ticketed events.

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 be posted on the bulletin board in the front lobby. Failure to comply with these guidelines can result in suspension from The Aliveness Project.

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Membership Application

Verification of Eligibility for Membership

APPLICANT Please print unless signature required

I _____ _____
Full Name of Applicant Date of Birth

authorize _____
Name of Physician

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

X _____ _____
Applicant's Signature Date

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

PHYSICIAN Please print unless signature required

This form is solely to establish eligibility 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-positive.

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 Date of Birth

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

X _____ _____
Physician's Signature Date

Date of last medical appointment: _____

Date viral load/CD4 was verified: _____

Clinic/Agency: _____

Office Address: _____

Phone: _____ Fax: _____

Please return form:

Fax **-or-** **Mail**

612-822-9668

Director of Member Services
The Aliveness Project
3808 Nicollet Avenue
Minneapolis, MN 55409

Questions about this form?

Please contact our Member Services Director at 612-822-7946.