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@aliveness.org
See attached guidelines/eligibility criteria form.

EPC Client # ____________

PE Client # _____________

(for office use only)
7/1/24 – 6/30/25
Prior forms no longer valid

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	
City	State Zip *(Required)*	OK to Send EPC Mail ☐ YES ☐ NO	
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): _____________

Required Eligibility Documentation **You must provide proof of Ryan White eligibility.**
Please submit a copy of *AT A Glance* showing you are open and eligible to receive Ryan White services. You may get a copy of your *At A Glance* from your HIV Provider or EPC staff.

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.

Race (*Select one or more)*:
☐ White ☐ American Indian ☐ Alaska Native ☐ Asian
☐ African American/Black ☐ Native Hawaiian ☐ Pacific 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 ☐ Bisexual ☐ Queer

☐ Straight/heterosexual ☐ Other____________________

HIV/AIDS Status (Select one)**:**

☐ HIV positive, not AIDS
☐ HIV positive, AIDS Status Unknown
☐ Have AIDS diagnosis
☐ HIV Diagnosis Pending – Pediatrics Only

Check box below if date is estimated

Date of HIV Diagnosis _________________________ Month/Day/Year ☐ 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: ☐ Men who have sex with men ☐ Hemophilia
Select one or more ☐ Injection Drug Use ☐ Blood Recipient ☐ Other
☐ Heterosexual Sex ☐ Perinatal Transmission ☐ Unknown

Health Insurance: ☐ Private ☐ Other
Select one or more ☐ 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'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. Being resubmitted does not mean that you will automatically be drawn.

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 Aliveness Project. I also acknowledge I have received a copy of the Aliveness Project Client Bill of Rights, Grievance Procedure and Data Practices Notice. I acknowledge that the information provided in this application is true and I authorize Aliveness Project to verify the accuracy of the information as necessary.

_______________________________________ _________________
Signature Date