

## **Minnkota Health Project**

P.O. Box 219

810 4<sup>th</sup> Ave. S Suite 202, Moorhead, Minnesota 56560

218-287-4636 or 877-871-4636

[minnkota@mhpmc.org](mailto:minnkota@mhpmc.org)

Fax: 218-477-0373

### **CLIENT ELIGIBILITY STATEMENT**

**MINNKOTA HEALTH PROJECT** services are available for people living with HIV/AIDS, their partners, families and caregivers in Greater Minnesota and east-central North Dakota. Please read the following carefully. Failure to complete the application or provide correct documentation may result in delay of meeting of some needs.

#### **SERVICES PROVIDED:**

- Individual Counseling and Support Groups. Counselors are available to provide counseling for people living with HIV/AIDS, their partners, families, and caregivers. Clients may call or stop by to schedule appointments. Phone counseling is also available. Clients who live in eastern North Dakota are able to access individual and group emotional support services.

Support groups meet once per month in Bemidji and Glenwood, and twice per month in Brainerd and Moorhead.

- Care Advocacy. Our counselors are advocates, too. They are knowledgeable about the resources available in our service region and statewide. They pay attention to a client's individual needs and make referrals to appropriate resources, including medical care, medication coverage, and social services.
- Transportation Assistance. People living with HIV/AIDS within our Minnesota service area who meet income requirements are eligible for transportation assistance. Assistance is provided for travel to and from counseling, support groups, medical appointments, trips to the pharmacy and other types of social services through Rural AIDS Action Network.
- Food Program. Minnkota sponsors a monthly food program for clients who live at or below 300% of the Federal Poverty Level. Clients receive a monthly food distribution voucher or grocery reimbursement for food purchases that meet nutritional guidelines. This service is available to clients living in Greater Minnesota and eastern North Dakota.

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### **MINNKOTA HEALTH PROJECT PROGRAM GUIDELINES**

- Verification of income, in the form of a letter from Social Security or Public Assistance or a pay-stub will be required.
- Applicants need verification of their HIV+ status; this may be a statement from a physician, case manager, social worker or other HIV service provider. An applicant can complete a Release of Information to any of the above parties, and then the Minnkota Health Project will obtain verification of HIV+ status.
- Participants must live in Greater Minnesota or east-central North Dakota. If client moves to an area outside of the Minnkota Health Project service area, referrals will be made to appropriate agencies.
- Participants must complete the application forms and sign them. Personal information will be collected and only used for the following purposes:
  - To identify the services people living with HIV need and use
  - To identify barriers to those services
  - To evaluate future funding needs

Applicants have the right to refuse to sign the application, which allows for the release of the above information; however, it may prevent their participation in various programs.

- Funding for this program is determined by the State of Minnesota and other funding sources. During the grant period, program guidelines may change based on needs and/or the availability of funds. Funding is only assured throughout each grant period and is subject to renewal at the end of each grant period.

In order to be eligible for services by Ryan White CARE Act Title II, all recipients of funded services must reside in Minnesota and have annual incomes at or below 300% of the Federal Poverty Level, as outlined below.\*

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Family Size	Annual Income
1	\$32,490
2	\$43,710
3	\$54,930
4	\$66,150
5	\$77,370
6	\$88,590
7	\$99,810
8	\$111,030
9	\$122,250
10	\$133,470

### INCOME STATEMENT:

My monthly income is: \$ \_\_\_\_\_ x 12 = \$ \_\_\_\_\_ (annual income)

- My annual income exceeds the guidelines listed above.
- Attached is proof of income in the form of: \_\_\_\_\_  
(pay stub, social security determination letter, etc.)
- I declare that my annual income is less than 300% of the Federal Poverty Level, but I am unable to provide proof of my annual income at this time because:

Reason: \_\_\_\_\_

Signature: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

**NOTE:** You will not be denied services from the Minnkota Health Project even if your income exceeds these guidelines. Our services are available to anyone living with HIV/AIDS.

\*North Dakota clients are eligible for Emotional Support Group services and are referred to their county nursing services to access Ryan White funds for transportation.

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### **Informed Consent, Client Rights Standards of Care**

#### **Mission**

The Minnkota Health Project's mission is to provide client-centered, barrier-free services to persons whose lives are affected by HIV/AIDS. The Minnkota Health Project was formed in the late 1980s as an all-volunteer, grassroots effort by people living with HIV on behalf of people living with HIV/AIDS. The Minnkota Health Project is focused on providing services for people living with HIV/AIDS, their partners and families living in western Minnesota and east-central North Dakota.

#### **Service Area – Rural Western Minnesota and Rural East-Central North Dakota**

The program is intended to support you, the client, in identifying needs and addressing them through an individualized plan of care. This program attempts to respond to the broad range of physical, emotional, and social barriers individuals living with HIV and AIDS may encounter. Any rural person in Rural Western Minnesota and Rural East-Central North Dakota living with HIV/AIDS is eligible for the Minnkota's services.

#### **Duration of Services**

The Minnkota Health Project is funded through government grants, foundation grants, and private donations. Services will conclude when the agreed-upon goals have been met, if you relocate outside the service area of the Minnkota Health Project, if funding for this service is discontinued, or when contact between you and your case worker has been determined by either party to be ineffective.

#### **Client's Rights and Responsibilities**

As a client of the Minnkota Health Project, it is important for you to notify staff of any changes in address and/or telephone number to achieve regular and effective communication. In addition, you may be asked to sign agreed-upon release of information forms so staff can communicate with other service providers to eliminate barriers and help you make progress on your goals. If you choose not to give your Care Advocate consent to talk with others involved in your care, services may be affected.

As a client, you have the right to:

- be treated with respect and dignity;
- receive service which is nondiscriminatory and sensitive to differences of race, sex, age, ethnicity, sexual orientation, religious traditions, disability, economic status, or marital status;
- confidentiality regarding records and information;
- request a change in service or cancel service at any time;
- decide course of treatment; and decline services.

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### **Data Privacy Guidelines**

By agreeing to participate in any service provided by the Minnkota Health Project, you will be asked to provide information at the time of enrollment and periodically thereafter which will assist in data collection, assessment, and the determination of an individualized plan of care. This information may be provided in aggregate to Minnkota Health Project's government funders in accordance with contract agreements; however, Minnkota Health Project will maintain your confidentiality as outlined below at all times. Data provided to our funders will not identify you by name or include any other identifying personal information.

Any information about you will be maintained in a confidential manner by Minnkota Health Project, with access limited to the staff involved in your care, and to others for whom you have provided consent for Minnkota Health Project to share or discuss your information. Any identifiable information obtained in connection with your participation with Minnkota Health Project will be disclosed only with your known consent. You will not be identified or identifiable in any written reports or publications. Our government funders require that some personal information be collected and reported to them in order to:

- identify the services individuals with HIV/AIDS need and use;
- identify barriers to those services; and
- evaluate future funding needs.

The Minnkota Health Project also may be required to release information about you in the following circumstances:

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

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### **Grievance Procedure**

If, at any time during the course of your involvement with Minnkota Health Project, you experience concerns that warrant formal attention, you are encouraged to resolve the concern directly with staff. If this proves unsatisfactory, if you determine that doing so would jeopardize your relationship with this provider, or if you are concerned for your personal safety, you may contact Minnkota Health Project's Executive Director at 877-871-4636. With input from you, the Executive Director will promptly and appropriately investigate and address the concern. The Executive Director will prepare a written summary of the presenting concern and the agreed-upon plan of resolution. This summary will be presented to you and the staff involved within one week of the initial grievance. A copy of the written report also will be kept in your Minnkota file. If your concern has not been resolved to your satisfaction after completing this procedure, you may file your complaint in writing with:

Board of Directors  
Minnkota Health Project  
PO Box 219  
810 4th Avenue South, 202  
Moorhead, Minnesota 56560

HIV/AIDS Programs  
Department of Human Services  
PO Box 64972  
St. Paul, Minnesota 55164-0972

By signing below, you acknowledge that you have read and understand the above information and agree to receive services provided by the Care Advocate Program at Minnkota Health Project. You may, without consequence, withdraw your participation from the program at any time after signing this document. You 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.

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Client Signature

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Date

---

Client Name (Please Print)

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Care Advocate Signature, Minnkota Health  
Project

---

Date

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**A. GRIEVANCE PROCEDURE**

If a consumer has a complaint about services or a Minnkota Health Project staff, intern and/or a volunteer, the individual is encouraged to follow our complaint procedures:

Step 1:

Discuss the complaint with the individual against whom the complaint is made. If unable to resolve the situation, go to Step 2. If the consumer believes he or she is unable to approach this individual, he or she can go to Step 2.

Step 2:

File a written complaint with the Executive Director no later than one calendar year after the act complained of occurred.

Clinton Lende, Executive Director  
Minnkota Health Project  
810 4<sup>th</sup> Avenue South, Suite 202  
Moorhead, MN 56560

The Executive Director shall make every effort to resolve the complaint informally, including mediation with the parties involved. All written complaints, even if resolved at Step 2, will be presented to the Board of Directors.

If the consumer is unsatisfied with the outcome of Step 2, he or she may go to Step 3.

Step 3:

If the Executive Director has not resolved the complaint, the consumer may file with the Board of Directors. The Minnkota Health Project Board of Directors has the final decision concerning the policies of the Minnkota Health Project or the conduct of any paid staff, intern, and/or volunteer. **Recommendations will be made by the Board and communicated to the consumer within 10 working days of hearing the written complaint.**

If the Board's decision is unacceptable, the consumer has the right to contact appropriate local, state, and/or federal agencies concerning the complaint.

**B. WITHDRAWING A GRIEVANCE**

The consumer may withdraw the grievance at any time during the grievance process and the grievance process will be considered terminated.

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### **Authorization to Provide Care**

Name: \_\_\_\_\_

#### **AUTHORIZATION TO PROVIDE CARE**

I hereby authorize Minnkota Health Project to provide care through its personnel, which may include but is not limited to care advocacy, referrals, education, emotional support, and education with respect to my condition. I have the right to refuse any service.

I understand there are some services that may not be available and are beyond Minnkota Health Project's scope of work. In this case, staff will assist me in locating additional services.

#### **CLIENT RIGHTS**

I acknowledge that I have read and received a copy of my rights as a client and also of the grievance procedure. I understand that if I have any questions, I have the right to file a complaint with the Director of Minnkota Health Project.

#### **CLIENT RESPONSIBILITIES**

I will develop a plan to address needs with assigned staff.

I understand that Minnkota Health Project reserves the right to refuse services to me in the event that I do not follow the plan the agency and I have agreed upon.

#### **CONFIDENTIALITY**

I understand that my records will be held in strict confidence. Release of information will not be given without my specific written consent or specific verbal request except as required by law. I understand that in order for any staff to communicate with other service providers, I must provide them with a release to establish contact and exchange information. I also understand that these releases can be revoked at any time.

#### **AUTHORIZATION TO RELEASE INFORMATION**

I give permission to the Minnkota Health Project personnel to disclose my medical condition including my HIV diagnosis in the following circumstances:

- there is a subpoena and a court order mandating us to release your records for a legal proceeding;
- you are threatening to harm another person and have stated both the identity of that person and the means by which you plan to harm them;
- you are threatening to seriously harm yourself and have identified a means by which you plan to do so;
- it is suspected that you are being mistreated by a caregiver or are not able to protect yourself from mistreatment; or
- there is reason to believe you are abusing or neglecting a child or vulnerable adult.

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**AUTHORIZATION TO COLLECT QUALITY ASSURANCE DATA**

I understand that my records may be reviewed by qualified professionals as part of a quality assurance process to ensure care that meets federal professional standards. I understand that these professionals are held to the same requirements to protect my confidential information.

**SIGNATURES:**

I have read, have had the above statements explained to me by a Minnkota Health Project representative, or have been read the consents in my native language by an interpreter. By my signature I agree to all the conditions set forth in this agreement. I understand that I may terminate this agreement with Minnkota Health Project in writing at any time.

Signature of client: \_\_\_\_\_

Date: \_\_\_\_\_

If Client is Unable to Sign:

Signature of person authorized to sign for client: \_\_\_\_\_

Relationship to client (POA, interpreter, spouse, etc.) \_\_\_\_\_

Reason client is unable to sign: \_\_\_\_\_

Witness to signature if client is unable to sign: \_\_\_\_\_

Date: \_\_\_\_\_

**Minnkota Health Project  
Verification of HIV Status**

Return form to MHP, P.O. Box 219, Moorhead, Minnesota, 56561 or Fax: 218-477-0373

**Consent for Release of Information**

The Minnesota Department of Health funds this program and requires some personal information be collected and reported periodically for the following purposes:

- To identify **services** persons with HIV/AIDS need and use.
- To identify **barriers** to those services.
- To evaluate future funding needs.
- To establish eligibility for services.

We **are required** to enter your name and other identifying information into a limited-access data base of the Minnesota Department of Health as a condition of funding at the time of enrollment and periodically thereafter to assist in data collection.

**I consent to the release of information regarding me for the above purposes.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Physician Verification and Information**

I certify that \_\_\_\_\_ has a diagnosis of HIV/AIDS.

Physician (print name) : \_\_\_\_\_

License # : \_\_\_\_\_

Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Statement of Confidentiality**

All records related to Minnkota Health Project clients are protected by Federal Law which prohibits further disclosure of any information without the specific written consent of the person to whom it pertains.

**Minnkota Health Project  
Intake Form A**

**INSTRUCTIONS:**

1. Please complete both sides of application and attach verification of income.
2. You may provide one of the following as proof of income. Income verification you have attached:
  - Most recent pay stub
  - Benefit statement
  - Copy of last years tax return

**Section A. (Required)**

**Name:** \_\_\_\_\_  
(first, middle, last)

**Date of Birth:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_ Yes, call me at this number \_\_\_\_\_ No, do not call me at this number

**Did you move to Minnesota within the last six months?** \_\_\_\_Yes \_\_\_\_No

**Address:** \_\_\_\_\_

\_\_\_\_\_ can send mail to this address \_\_\_\_\_ cannot send mail to this address

**Section B. (Required)  
Income Verification**

**Anticipated Monthly Income:** \_\_\_\_\_

**Number of people living with you and legally dependent on this income:** \_\_\_\_\_

**Disability Status:** \_\_\_\_\_

**Section C. State Requested Information**

You have the right to refuse to answer any question in Section C. Information is used to collect demographic data concerning those living with HIV/AIDS in the state of Minnesota and North Dakota.

**GENDER:** (circle one)

- Male
- Female
- Transgender, Male to Female
- Transgender, Female to Male

**RACE:** (circle one)

American Indian / White / African American, Black / Asian / Pacific Islander / Hispanic / Latino / Other: \_\_\_\_\_

**Ethnicity:** (Circle one) Hispanic / Non-Hispanic / Unknown

**LIVING SITUATION:** (circle one):

Homeless, Permanent Housing, Non-permanent Housing, Institution, Other \_\_\_\_\_

**DIAGNOSIS INFORMATION:**

Year diagnosed with HIV: \_\_\_\_\_ Year diagnosed with AIDS: \_\_\_\_\_

How were you exposed? \_\_\_\_\_

(Male to Male sex, Male to Female sex, Injecting Drug User, Blood Recipient, Hemophilia, Parental Transfer, Occupational Exposure, Other, Refused, Unknown

**Have you seen an HIV medical provider in the last 6 months?** Yes Date: \_\_\_\_\_ No

**Section D.  
Health Insurance**

(Circle one)

Private: \_\_\_\_\_

Medicare                  Medicaid                  MCHA                  Refused                  Unknown

**Country of Birth:** USA Other: Specify \_\_\_\_\_ Refused          Unknown

**Office use only—Intake is complete with staff has:**

- Documented income source \_\_\_\_\_
- Verification of HIV/AIDS Serostatus \_\_\_\_\_
- Reviewed the Intake A Form with Client

**Additional Needs Identified During Intake:**

- |   |   |
|---|---|
| <input type="checkbox"/> Medical Care/ Provider       | <input type="checkbox"/> Dental Health            |
| <input type="checkbox"/> Mental Health and Well Being | <input type="checkbox"/> Drug Insurance/Adherence |
| <input type="checkbox"/> Pet Care/Health Concerns     | <input type="checkbox"/> Food Assistance Programs |
| <input type="checkbox"/> Support Groups/Social Groups | <input type="checkbox"/> EPC/HOPWA Assistance     |
| <input type="checkbox"/> Other                        | <input type="checkbox"/> RAAN Services            |

**Welcome!**  
Minnkota Support Group Members

**Who We Are:**

Support Group is open to those living with and affected by HIV/AIDS. Minnkota Health Project is a non-profit organization which provides services for people living with HIV/AIDS, their partners and families in western Minnesota and east central North Dakota. All groups are led by trained, experienced professionals. In addition, individual emotional support is available in the office or by regular phone contact to those needing sustained emotional support outside of the group meetings.

**Our Mission:**

To provide concerned and compassionate emotional and social support for those infected and affected by HIV/AIDS.

**What To Expect From Your First Meeting:**

A safe, welcoming environment. You can share or choose to relax and simply listen.

**Group Rules:**

- Group starts and ends at the scheduled time. (Please be considerate and arrive on time.)
- Cell phones are not allowed during group. (Please turn off all cell phones when you arrive.)
- Group members are not required to share. (Please respect one another's desires to disclose.)
- No one is allowed to try and "fix" another's problems.
- All members must notify the group facilitator when bringing a friend/family member or other supportive person to group.

**My Responsibilities:**

- To arrive on time and enter quietly if I should arrive late.
- To turn off cell phones before entering the meeting.
- To respect other's desire to disclose or not to disclose.
- To not make statements about one's situation, rather inquire politely.
- Let the facilitator know I plan on attending support group and if any one else will be with me.

**CONFIDENTIALITY:**

Every Member should respect the confidentiality and anonymity of individual group members.

## **Minnkota Health Project Confidentiality Contract**

I understand that the relationships and information shared at support group are strictly confidential, and any member that acquires certain facts relative to clients attending a Minnkota support group must keep information strictly confidential.

I understand that under no circumstances is the business or medical affairs of clients of the Minnkota Health Project to be discussed with any outside party without permission of the client. I understand that this would be a breach of confidentiality.

I understand that if I breach confidentiality, I may be immediately dismissed from the support group.

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Print Name

---

Signature

---

Facilitator Signature

---

Date



**Minnkota Health Project**

**Minnkota Center**

810 4<sup>th</sup> Ave. South, Suite 202, Moorhead, Minnesota 56560

(218) 287-4636 • 1-877-871-4636

Fax: 218-477-0373

**AUTHORIZATION TO RELEASE PROTECTED INFORMATION**

**CLIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**AGENCY/CONTACT NAME AUTHORIZED TO RELEASE INFORMATION**

Name of Person/Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**INFORMATION TO BE DISCLOSED**

- |   |  |
|---|--|
| <input type="checkbox"/> MEDICAL DIAGNOSIS  | <input type="checkbox"/> MEDICAL HISTORY                 |
| <input type="checkbox"/> LAB/PATHOLOGY REPORTS  | <input type="checkbox"/> MENTAL HEALTH EVALUATIONS       |
| <input type="checkbox"/> TREATMENT SUMMARY  | <input type="checkbox"/> CHEMICAL DEPENDENCY EVALUATIONS |
| <input type="checkbox"/> DISCHARGE SUMMARY  | <input type="checkbox"/> SUMMARY OF SOCIAL HISTORY       |
| <input type="checkbox"/> INFORMATION RELATED TO SEXUAL ORIENTATION OR GENDER IDENTITY | <input type="checkbox"/> OTHER _____                     |

**LIMITATIONS ON DISCLOSURE**

- NO LIMITATIONS PLACED ON DATES OR ILLNESSES
- LIMITATIONS REQUESTED TO AUTHORIZATION: DOCUMENTED IN CHART
- LIMITED TO THESE DATES \_\_\_\_\_
- OTHER \_\_\_\_\_

**REASON FOR DISCLOSURE**

- |   |   |
|---|---|
| <input type="checkbox"/> COORDINATION OF CARE                   | <input type="checkbox"/> COLLECT INFORMATION CONCERNING CLIENT  |
| <input type="checkbox"/> DISCLOSE INFORMATION CONCERNING CLIENT | <input type="checkbox"/> EXCHANGE INFORMATION WITH LISTED PARTY |
| <input type="checkbox"/> OTHER                                  |   |

I understand that no disclosure of my records can be made without my written consent unless otherwise provided for in legal statutes and judicial decisions. I understand that I may revoke this consent at anytime except to the extent that action has already been taken upon this release. This authorization will automatically expire one year from the date of my signature. All items of this form must be completed for this authorization to be valid.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized (Parent, Guardian, Power of Attorney)

\_\_\_\_\_  
Date