Public Health Management Corporation

APPLICATION COVER PAGE

Agency: _____

Address: _____
Street City State Zip Code

Medical Case Manager /Housing Counselor_____
(Print Name)

Phone: _____

Fax:_____ Email: _____

I attest the information and documentation submitted is accurate and verified by me.

_____
(Signature)

Date:_____

Fax the application to 215-985-2099. Attn: DEFA COORDINATOR
This is a secured fax number, do NOT use any other PHMC fax number for this purpose.
DO NOT SEND the application via MAIL

Place a √ next to the application pages to be submitted. Please review Program Guide and make sure all required documentation is included with the application.

☐ Page 2, Applicant Demographic & Personal Data
☐ Page 3, Insurance & Applicant's Residence
☐ Page 4, Household Members
☐ Page 5, Financial Counseling Form
☐ Page 6, Certification of Medical Necessity
☐ Page 7, Intent to Rent Letter
☐ Page 8, Statement of Back Rent
☐ Page 9, Vendor Information Form
☐ Page 10, Consent for Service Form

DATE OF APPLICATION: _____

APPLICANT NAME: _____

ADDRESS: _____
STREET/APT#/CITY/STATE/ZIP CODE

_____
STREET/APT#/CITY/STATE/ZIP CODE

COUNTY OF RESIDENCE: _____

DATE OF BIRTH: _____ SSN: _____

GENDER (check one): ☐ Male ☐ Female ☐ Unknown
☐ Transgender (please circle one): male to female female to male
Biological sex of applicant at birth (check one): ☐ Male ☐ Female

RACE & ETHNICITY: (Please note that both race and ethnicity are required of the applicant, this is based on the applicant's self-report. An applicant's response is sufficient for this purpose).

RACE (check all that apply): ☐ American Indian/ Alaska Native ☐ Asian ☐ Black /African American
☐ Native Hawaiian/Other Pacific Islander ☐ White

If applicant answered Asian, please specify the following (check all that apply):
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

If applicant answered Native Hawaiian/Other Pacific Islander, please specify the following (check all that apply):
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

ETHNICITY (check one):
☐ Hispanic/Latino(a)/Spanish Origin ☐ Non-Hispanic/Latino(a)/Spanish Origin

If applicant answered Hispanic/Latino(a)/Spanish Origin, please specify the following (check all that apply):
☐ Mexican/Mexican American/Chicano(a) ☐ Puerto Rican ☐ Cuban
☐ Another Hispanic/Latino(a)/Spanish Origin

HIV RISK (check all that apply): ☐ MSM ☐ IDU ☐ Heterosexual Contact
☐ Hemophilia/Coagulation Disorder ☐ Perinatal Transmission ☐ Blood Transfusion
☐ Not Reported or Not Identified

MEDICAL INSURANCE (check one):

☐ Private Employer
☐ Private Individual
☐ Medicare
☐ Medicaid, CHIP or Other Public Plan
☐ No Insurance/Uninsured
☐ Other
☐ Unknown
☐ Veterans Health Administration (VA), Military Health Care (Tricare), & Other Military Health Care
☐ Other Plan (Client has an insurance type other than listed above)

CURRENT LIVING ARRANGEMENT (check one):

☐ Renting (unsubsidized)
☐ Permanently living with family/friends
☐ Institutional setting
☐ Substance abuse treatment facility or detox center
☐ Foster care home or foster care group home
☐ Temporarily staying with family/friends
☐ Temporary placement in institution
☐ Jail/ prison/juvenile/detention
☐ Hotel, or motel (paid with a government voucher)
☐ Emergency shelter or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a vehicle, an abandoned building, a bus/train/subway station/airport, or anywhere outside
☐ Own home/ apartment
☐ Subsidized housing
☐ Psychiatric hospital or other psychiatric facility
☐ Hospital
☐ Transitional housing for homeless individuals
☐ McAuley House, Good Shepherd, Calcutta
☐ Hotel or motel (paid w/o a government voucher)

How long have you lived there? _____

SUBSIDY INFORMATION:

Do you receive a housing subsidy?
☐ Yes ☐ No Source: _____

Do you receive low income housing?
☐ Yes ☐ No Source: _____

HOUSEHOLD COMPOSITION:

Family size: _____ (This is the number of family members who live together, including the applicant. An applicant living alone (or with **only** non-relatives) counts as a family of one).

Annual family income: _____ (This is the sum of income of all family members who live together. It includes pre-tax money or "cash" income (earnings; unemployment compensation; Social Security; public assistance; veteran payments; survivor benefits; pension or retirement income; interest; dividends; rents; royalties; income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources). It excludes non-cash benefits including food stamps, housing subsidies and capital gains or losses).

<u>HOUSEHOLD MEMBERS</u>:

Name of household member ____

DOB ____

Race (check all that apply): ☐American Indian/ Alaska Native ☐Asian ☐Black /African American
☐Native Hawaiian/Other Pacific Islander ☐White
Ethnicity (check one): ☐Hispanic/Latino(a)/Spanish Origin ☐Non-Hispanic/Latino(a)/Spanish Origin
Relationship to Applicant (check one): ☐Domestic Partner/Lover ☐Husband ☐Wife ☐Mother
☐Father ☐Son ☐Daughter ☐Sister ☐Brother ☐Other _________________________

Name of household member ____

DOB ____

Race (check all that apply): ☐American Indian/ Alaska Native ☐Asian ☐Black /African American
☐Native Hawaiian/Other Pacific Islander ☐White
Ethnicity (check one): ☐Hispanic/Latino(a)/Spanish Origin ☐Non-Hispanic/Latino(a)/Spanish Origin
Relationship to Applicant (check one): ☐Domestic Partner/Lover ☐Husband ☐Wife ☐Mother
☐Father ☐Son ☐Daughter ☐Sister ☐Brother ☐Other _________________________

Name of household member ____

DOB ____

Race (check all that apply): ☐American Indian/ Alaska Native ☐Asian ☐Black /African American
☐Native Hawaiian/Other Pacific Islander ☐White
Ethnicity (check one): ☐Hispanic/Latino(a)/Spanish Origin ☐Non-Hispanic/Latino(a)/Spanish Origin
Relationship to Applicant (check one): ☐Domestic Partner/Lover ☐Husband ☐Wife ☐Mother
☐Father ☐Son ☐Daughter ☐Sister ☐Brother ☐Other _________________________

Name of household member ____

DOB ____

Race (check all that apply): ☐American Indian/ Alaska Native ☐Asian ☐Black /African American
☐Native Hawaiian/Other Pacific Islander ☐White
Ethnicity (check one): ☐Hispanic/Latino(a)/Spanish Origin ☐Non-Hispanic/Latino(a)/Spanish Origin
Relationship to Applicant (check one): ☐Domestic Partner/Lover ☐Husband ☐Wife ☐Mother
☐Father ☐Son ☐Daughter ☐Sister ☐Brother ☐Other _________________________

Use an additional page if needed

Public Health Management Corporation

FINANCIAL COUNSELING FORM

Applicant Name:_____ Case Manager Name: _____

Current Address: _____
City/Town Zip Code

Proposed Address: _____
City/Town Zip Code

Please describe the circumstances leading to the current crisis. Use an additional page if needed.

I attest that I have received budget counseling with the goal of maintaining myself without need for further DEFA assistance.

Applicant Date

I attest that the applicant has received budget counseling pursuant to this application.

Case Manager Date

Public Health Management Corporation

CERTIFICATION OF MEDICAL NECESSITY

This form must be completed by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner.

Patient: _____

Medical Professional's Name & Address: _____

_____

Medical Professional's Telephone#_____

I certify that_____is currently facing complications in HIV related health status and/or the care and treatment of HIV/AIDS disease. Obtaining emergency financial assistance is medically necessary for the applicant to gain or maintain access and compliance with HIV related medical care and treatment.

Please answer the following:

HIV/ AIDS Status (circle one): 1. HIV- positive, not AIDS 2. HIV-positive, AIDS status unknown 3. CDC-defined AIDS 4.HIV-indeterminate (infants<2 only)

Determined HIV Seropositive_____(date of HIV diagnosis)

Patient had a viral load test in the last 12 months.____Yes ____No

Patient is on HIV medications.____Yes ____No

_____ _____

Medical Professional's Signature Date (valid for 90 days)

Public Health Management Corporation

INTENT TO RENT LETTER

The tenant_____will rent
(name of applicant)

property located at_____. The

landlord_____and tenant have
(name of landlord)

entered an agreement prior to the lease for 1st month's rent $_____ last month's rent

$_____ or security deposit $_____ for a total of $_____

in order for the tenant to occupy the above property.

NOTE: A security deposit funded by the Direct Emergency Financial Assistance (DEFA) Program must be returned to the Public Health Management Corporation. Please initial one of the statements below

_____Landlord will return the DEFA security deposit to Public Health Management Corporation upon termination of lease.

_____Tenant will return the DEFA security deposit to Public Health Management Corporation upon termination of lease.

_____Tenant is responsible for security deposit. DEFA funds will NOT be used for this purpose.

Signatures:

_____ _____

Landlord – Print Name Tenant – Print Name

_____ _____

Landlord – Signature Tenant – Signature

_____ _____

Date Date

Public Health Management Corporation

STATEMENT OF BACK RENT

The tenant_____ is currently
(name of applicant)

behind in rent. The landlord _____ and tenant have entered into a
(name of landlord)

repayment agreement, by which both parties have agreed to bring the tenant's rental account current.

The amount of the tenant's arrears is $_____ for _____

_____
(specify months and year)

_____	_____
Landlord – Print Name	Tenant – Print Name
_____	_____
Landlord – Signature	Tenant – Signature
_____	_____
Date	Date

Please note: The tenant is responsible for all late fees and service charges.

Landlord's Address:_____

Landlord's Phone Number: (____)_____

Public Health Management Corporation

VENDOR INFORMATION FORM

GRANT REQUEST: ☐ Back Rent ☐ 1st & Last Month Rent ☐ Mortgage ☐ 1ST Month & Security Deposit ☐ Heating Oil ☐ Essential Utilities ☐ Pharmaceutical		**PAYMENT DELIVERY:** ☐ Mail Check ☐ Pick Up Check
VENDOR COMPANY:		
CONTACT:		
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
TELEPHONE NO:	**FAX NO:**	
ACCOUNT NUMBER:	**AMOUNT REQUESTED $**	
GRANT REQUEST: ☐ Back Rent ☐ 1st & Last Month Rent ☐ Mortgage ☐1ST Month & Security Deposit ☐ Heating Oil ☐ Essential Utilities ☐ Pharmaceutical		**PAYMENT DELIVERY:** ☐ Mail Check ☐ Pick Up Check
VENDOR COMPANY:		
CONTACT:		
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
TELEPHONE NO:	**FAX NO:**	
ACCOUNT NUMBER:	**AMOUNT REQUESTED $**	
TOTAL GRANT AMOUNT REQUESTED: $		

Public Health Management Corporation

CONSENT FOR SERVICE FORM

I, _____ (print full name) am applying for Direct Emergency Financial Assistance (DEFA). I agree to cooperate with referring and administering agency staff in providing additional information, as required, to complete the application. I have answered the questions on the application form and have submitted all necessary documentation to support my request for assistance.

I consent to the agency's assessment of my financial need. The assessment is to identify possible resources to meet my needs in an ongoing way.

Applications are considered by the requirements outlined in the DEFA Program Guide. Agency staff will provide any assistance needed by applicants in the application and appeal process.

CONFIDENTIALITY STATEMENT

Assigning an "individual identification number" to the application and maintaining records in a locked file assures the applicant's privacy. Records are maintained for seven years and then destroyed. Application forms are open to inspection only to those professionals who are licensed or fund the activities of the DEFA program and for internal contract review, when necessary. Neither this agency nor its representatives will reveal the applicant's personal health or medical information to anyone without a release form in accordance with Pennsylvania Act 59 and the HOPWA Confidentiality User Guide, November 2013.

The Provider agency reserves the right to deny or limit service based on its professional judgment of needs. A negative decision will be discussed with you. You have the right to appeal this decision. The agency will make every effort to provide satisfactory service in every respect; however, if you should experience an unusual difficulty, please contact the agency's Executive Director who will act promptly to assist you. In regards to any of the above items, you may request a detailed copy of the agency's relevant appeals process. You may also request to appeal the decision by contacting the Health Information Helpline at 1-800-985-2437 or 215-985-2437.

This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or if authorization by the confidentiality of HIV-related information Act, 35 P.S. Section 7601. Et Seq. A general authorization for the release of medical or other information is not sufficient for this purpose.

APPLICANT STATEMENT

I have been offered, read and signed a copy of the agency's release form in accordance with Pennsylvania Act 59 and the HOPWA Confidentiality User Guide, November 2013 that will allow the agency to contact other organizations, companies or agencies that will allow this agency to collect information that may be required to complete my application.

I have been offered a copy of this Consent form which I ***accepted/ rejected*** (circle one).

I have read this application in full. All the information given to the agency concerning this emergency grant is correct to the best of my knowledge. If any information provided is found purposely inaccurate or false, I am responsible for paying back the money given to me, and I will not be able to re-apply for emergency funding.

_____

Applicant's Signature Date

_____

Case Manager's Signature Date