Bill's Pantry

217 Mackubin Street
St. Paul, MN 55102

Phone 651-228-0370
Fax 651 487-0381
www.billspantry.org
info@billspantry.org

Welcome to Bill's Pantry, Inc.,

We are a small but dedicated group of people in the Twin Cities who are concerned about nutritional needs of those living with HIV and AIDS. We aim to supply breakfast groceries on a weekly basis to persons who are HIV+, whose income is at or below 200% FPG, and who do not participate in another daily meal program. Clients are encouraged to pick up their groceries or have an identified person who picks up the groceries for them. We have a **very** limited number of volunteers who deliver groceries. *Referrals will be accepted from HIV case managers, social workers or medical personnel only.*

How Bill's Pantry Works

1.) Clients will receive their first grocery "shopping list" by mail. After that they can complete an order when they come to pick up their groceries. Persons having grocery delivery will get an order form in their bags and MUST CALL IN THEIR ORDER TO OUR OFFICE BY FRIDAY NOON. Have your name, address, phone number and leave the order on our answering machine line at (651) 228-0370.

2.) Bill's Pantry, Inc. will be open on Saturdays from 10AM to 12PM. People picking up their order will have "bonus groceries" available to them. Volunteer drivers will also make deliveries during this time.

3.) If you cannot pick up your own groceries, you can designate a person to pick them up for. We will need to know who this person is prior to Saturday morning.

4.) We cannot hold orders for later pick up. People who are not home when their volunteer comes will not receive a delivery. Plan to be home from 11AM-2PM.

5.) We are entirely staffed by volunteers who are donating their time to help you. We will not tolerate violence, verbal abuse or mistreatment of any of our volunteers. Clients will receive only one warning before being removed from the program.

Please sign below to indicate your understanding and agreement to comply with Bill's regulations as outlined above.

Name ____ Date _____________

Bill's Pantry Intake Form

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Name (We need middle initial) ______________________________
First Middle Initial Last

Address: ______________________________ Date of Birth: __________
Apt. #
____

Phone: ______________________________ Age Today: __________
Area Code

Gender: __________ HIV: ______ Height: _____ Weight: _____

Race: __________ AIDS: ______

Anticipated Annual Gross Income: $__________
Number of persons dependant on income __________

Living Situation:
Homeless on Streets ________ Own/Rent: ______
Homeless Shelter: ________ CD Treatment: ______
Transitional: ________ Hospital/Med. Facility: ______
Living with friend/relative: ________ CD Treatment: ______

Exposure:
Male to Male ________ IV Drug Use: ______
Male to Female: ________ Hemophilia: ______
Blood recipient: ________ Other: ______

Insurance Status: ______________________________

Other food program(s) you participate in:
Food Stamps: __________ Monthly Amount: $__________
Aliveness Project: Congr. Meals _____ Food Shelf _____ Milk Vouchers: ______
Open Arms: Days/Week __________ Fare Share: __________
Other Food Shelves: ______________________________
Please specify

I verify client has tested positive for HIV: ______________________________

Case Manager, Social Worker, Physician making referral: ______________________________

Organization: ____________________ Signature: ____________________

Date: ____________________ Telephone: ____________________

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