IX. **American Lung Association (ALA)**

A. **ALA Incentive Funds**

1. Limited funds are available from the American Lung Association for the health department TB nurses to purchase or provide incentives to ensure treatment completion for tuberculosis and latent TB infection.
2. The health department must develop a policy on how the funds will be accessed by the nurse. The American Lung Association will provide a check to the local health department after receiving the approved documentation.
3. Incentives may be used to cover the basic needs of the patient, such as, food, transportation, purchase of other prescription medications, assistance with utility bills, or other needs identified by the TB nurse. Alcohol or tobacco products may not be provided with these funds.
4. The base request amount is $50. In rare instances, a larger amount may be approved. A letter of justification must accompany any request for more than $50.
5. Procedure for TB nurse:
   - Legibly complete the initial incentive fund application. A new initial application must be completed each calendar year.
   - Provide all information requested on the application.
   - Complete a W-9 form (https://www.irs.gov/pub/irs-pdf/fw9.pdf) for the health department. This must only be done once so that the American Lung Association will have the information on file.
   - Fax or e-mail the application and W-9 form if applicable, to your regional TB nurse consultant.
   - Maintain a copy of the application in the health department files.
   - When the $50 has been spent, complete the incentive fund application/expenditure report form; attach legible receipts and fax or e-mail to your regional TB nurse consultant.
   - If additional funds are needed indicate on the form that you are requesting another $50. Funds must be spent in the year they are received. All receipts must be submitted by December 31 for the nurse consultant to submit it to the Lung Association no later than January 4.
6. Procedure for N.C. TB control nurse consultants:
   - The regional TB nurse consultants will review and approve applications.
   - The regional TB nurse consultant will maintain a record of incentive program applications.
   - The regional TB nurse consultant will approve the application and fax or e-mail the application to the American Lung Association, attaching all applicable receipts.
   - At the beginning of each December, the nurse consultant will send a reminder to the nurses that all receipts for the current calendar year need to be submitted no later than December 31.
6. Procedure of the American Lung Association:
   - After receiving an application approved by the regional nurse consultant, the American Lung Association will mail a check to the health department indicated on the application form.
   - The American Lung Association will give N.C. TB Control a report of incentive funds monthly.
• At the beginning of each December, the American Lung Association will send a reminder to the N.C TB Control that all receipts for the current grant period (January-December) must be received by the Lung Association no later than January 4.

B. **Housing Funds**

1. Housing fund application form A must be completed and signed by the local health department nurse and the landlord/rental agent.
3. Housing fund application form B must be completed and signed by the local health department nurse and the patient.
4. Housing must be the lowest cost available, have prompt availability, and be safe for the TB nurse to visit. The following criteria must also be met if the patient is sputum smear positive:
   - No shared air space with other leased areas.
   - An exit or hallway that leads directly outside.
   - No housing employee shall enter the patient’s room until eight hours after the patient is considered non-infectious. Housekeeping arrangements must be worked out for individual situations.
5. Housing funds may not be used for deposits for apartments or utilities, a lease for an extended period or payments to family members or the patient.
6. A new application must be completed after 30 days.
7. A signed treatment agreement should be in place.
8. Priority will be given to smear positive or homeless people.
9. Procedure for the local health department TB Nurse:
   - Call to discuss the situation with the regional TB nurse consultant. If no other options exist for housing the regional TB nurse consultant will ask the health department nurse to complete the housing fund application.
   - Identify appropriate housing and have the rental agent or landlord sign the application – Form A.
   - Explain criteria for getting housing funds to the patient and have the patient sign the application – Form B.
   - Fax the completed application (Forms A and B) to the regional TB nurse consultant.
   - Refer the patient to social services and/or other resources to assist patient in meeting his own housing needs.
   - Re-submit a new housing fund application each time rent is due.
10. Procedure for N.C. TB Control:
    - The regional TB nurse consultant will review and approve housing fund applications and fax the application and W-9 form to the American Lung Association.
    - The regional TB nurse consultant will maintain a file of housing funds applications.
11. Procedure for the American Lung Association:
    - After receiving a housing fund application that has been approved by the regional TB nurse consultant the American Lung Association will issue a check to the rental agent or landlord.
    - The American Lung Association will give N.C. TB Control a report of housing funds monthly.
C. Funds for Utility Bills
The American Lung Association funds may be used to pay for utilities.
1. Procedure for the local health department nurse:
   • Complete form C;
   • Attach a copy of the utility bill; and
   • Fax the application to the regional TB nurse consultant.
2. Procedure for NC TB Control:
   • Review the application, and if approved, fax to the American Lung Association. If the need is time sensitive, the fax cover sheet should clearly note the urgency. A follow up email should be sent to the American Lung Association noting that an emergency request has been faxed.
3. Procedure for the American Lung Association:
   After receiving an application for payment of a utility bill, the American Lung Association will issue a check to the utility company along with a copy of the bill or in the case of an emergency, will pay by credit card. The Lung Association will confirm payment with the nurse consultant.
Incentive Fund Application/Expenditure Report
Grant Number 5040-NCTB-4219
Fax to Regional TB Nurse Consultant

County Health Department: __________________________________________________________

Make check payable to: __________________________________________ Attention: _______________________

Address: __________________________________________________________________________
City, State, Zip: ________________________________________________________________________

Phone: _________________ ext.: ____ Fax: ________________________________

County TB Nurse: __________________________ Email: _________________________________

☐ Check here if Initial Application for the Incentive Program

I wish to participate in the incentive program and hereby request an initial check for $50.00.

I understand that I may use these funds for patient compliance with treatment of TB disease or LTBI.

If I leave my present position, I will:
• submit an expenditure report of the funds expended and the remaining local fund balance
• notify the regional TB Nurse Consultant of the name and address of the agency nurse who has the balance of unused funds to continue the local incentives program.

☐ Check here if Expenditure Report with Receipts Attached
From (date) ___________________ through (date) ______________________

Indicate what previous funds were used for

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<tr>
<th></th>
<th>Beginning balance</th>
<th>Amount(s):</th>
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<tbody>
<tr>
<td>Food:</td>
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<tr>
<td>Meals/fast food</td>
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<tr>
<td>Groceries</td>
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<td>$</td>
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<tr>
<td>Nutrition (Ensure, etc.)</td>
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<td>Transportation:</td>
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<td>Bus fare</td>
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<td>Taxi fare</td>
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<td>$</td>
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<tr>
<td>Gasoline reimbursement or gas cards</td>
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<tr>
<td>Other:</td>
<td></td>
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<tr>
<td>Special incentives for children</td>
<td></td>
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<tr>
<td>Gift certificates/card for necessary items</td>
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# helped # Cases: # Contacts: # Reactors: Total #

☐ Check here if you are requesting another $50.00 incentive check

My signature certifies that the funds have been expended in accordance with Incentive Fund guidelines.

________________________________________ ________________________
County Nurse Signature Date

________________________________________ ________________________
TB Nurse Consultant Signature Date
Housing Fund Application
FORM - A Grant Number 5040-NCTB-4221
Fax to Regional Nurse Consultant

Nurses’ Name: ____________________ County Health Department: ____________________
Address: ______________________________________________________________
City, State, Zip: ____________________
Phone: ____________________ ext. ______ Fax: ____________________
Email: ____________________

Payment Request for Housing ☐ Initial Request ☐ Subsequent Request

Amount: $ ____________________ for ____________________ through ____________________
(Note: Cannot exceed 30 days) ____________________ Date ____________________

Contact person for housing (landlord/rental agent) __________________________________________

Phone: ____________________ extension: ______ Fax: ____________________

Check to be written to: __________________________________________

Federal Tax ID number: ____________________

Address: City, State, Zip: __________________________________________

County (if different from HD): ____________________

The housing agent hereby agrees to comply with the following, and thereby, will hold harmless NC DHHS, American Lung Association, the health department and its agents from liability:

1. Provide housing with no shared air space with other leased areas
2. Provide housing with an exit that leads directly to the outside or to a hallway that leads directly to outside
3. Allow no housing employee to enter the client room until 8 hours after the client is determined by the PH Nurse to be non-infectious. Housekeeping and linen supply arrangements are as follows:
   •
4. Provide single occupancy housing and report any patient problems to the health department nurse
5. Maintain the confidentiality of the individual for whom housing is being provided. The above housing agent has agreed to provide housing for the above costs.
   • I have been given a copy of this agreement.
   • I have provided a W-9.
   • I agree to the above conditions as housing agent and understand that the confidentiality of the individual is legally protected and that anyone who violates the person’s confidentiality may be subject to prosecution.

____________________________________ __________________________
Signature of Health Department Nurse Date ____________________

____________________________________ __________________________
Signature of Housing Agent (Required only on Initial Payment Request) Date ____________________

Regional Nurse Consultant’s Approval Signature ____________________

NC TB Control Policy Manual (Rev. 10/2020)
FORM - B
Grant Number 5040-NCTB-4221
Client – Health Department Agreement for Housing

I, __________________________, certify that I have no fixed, regular and/or adequate night-time residence at this time and I am unable to provide current shelter for myself.

I understand that I have confirmed or suspected active TB disease and treatment is necessary. I understand that, at this time, I am considered
☐ infectious to others  ☐ not infectious to others

I understand that the arrangements have been made for temporary housing during treatment and that I must:

1. Be at __________________________ on ________________________ at __________ am/pm to take my medicine.

2. Keep clinic appointments and have necessary laboratory tests.

3. Notify the health department nurse of any problems with the medicine or other emergencies.

4. Avoid alcohol or other drug use.

5. Not visit with other people in the housing area or other indoor areas until the health department nurse tells me I am no longer infectious to others.

6. Follow housing conditions by not having anyone else stay overnight, unless prearranged in the lease; not make any charges to the housing; and not make any long distance phone calls charged to the housing.

7. Allow the health department to identify me by name to the housing agent, N.C. TB Control and American Lung Association, if needed.

8. If the infectious to others box is checked, I cannot leave the rental unit except to go outside, until the health department nurse says I am no longer infectious to others.

• I have been given a copy of this agreement.
• I understand that I will be responsible for any damage to the rental property.
• I understand that if I violate the above I may lose the housing and may be subject to prosecution for violation of TB control measures which is a misdemeanor offense pursuant to G. S. 130A-25, punishable by incarceration until TB disease treatment is complete.

Client: _____________________________  __________________________
            Signature                      Date

Health Department Nurse: _____________________________  __________________________
            Signature                      Date
Emergency Funds for Utilities - Form C
Grant Number 5040-NCTB-4221
Fax to Regional Nurse Consultant

Nurses’ Name: ____________________________________________________________________________
County Health Department: __________________________________________________________________

Address: _________________________________________________________________________________
City, State, Zip: __________________________________________________________________________

Phone: (____)_________________ extension: ______
Fax: _____________________________________________________________________________________
Email: ____________________________________________________________________________________

Payment Request for Utilities   □ Initial Request   □ Subsequent Request

□ Electricity   □ Phone (basic service only)

□ Other (Specify):________________________

Check to be written to __________________________________________________________

Account number ________________________________________________________________

Amount: $__________________________________________

Address: City ,State ,Zip: ____________________________

A new form must be completed each time a utility bill needs to be paid. Deposits and past due / late fees cannot be paid using ALA funds. Attach a copy of the utility bill.

__________________________________________  _______________________
Signature of Patient                              Date

__________________________________________  _______________________
Signature of Health Department Nurse              Date

__________________________________________  _______________________
Signature of Regional Nurse Consultant            Date
**Form W-9**

**Request for Taxpayer Identification Number and Certification**

Go to www.irs.gov/FormW9 for instructions and the latest information.

1. **Name** (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2. **Business name/disregarded entity name**, if different from above

3. Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes:
   - Individual
   - Sole proprietor
   - Corporation
   - Partnership
   - Trust
   - Estate
   - Limited liability company

4. 
   - Exempt status code (for any Code C, D, E, F, or K income tax exemption)
   - Exempt status code (for any Code C, D, E, F, or K income tax exemption)
   - If the LLC is classified as a single-member LLC that is disregarded, see instructions or page 5
   - Exempt status code (for any Code C, D, E, F, or K income tax exemption)
   - Exempt status code (for any Code C, D, E, F, or K income tax exemption)
   - Exempt status code (for any Code C, D, E, F, or K income tax exemption)

5. **City, state, and ZIP code**

6. List account number(s) (optional)

### Part I: Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see how to get a TIN, later.

#### Social security number

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#### Employer identification number

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### Part II: Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding because of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have not been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part I, later.

**Sign Here**

Signature of U.S. person

**Data**

#### General Instructions

Section references are to the internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

**Purpose of Form**

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN), which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amounts reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (Interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1098-H (merchant card and third party network transactions)
- Form 1098-MORT (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1098-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.