REFERRAL CHECKLIST
Please use the following checklist to ensure that all required documents are completed.

☐ **Client Information:** Please complete to the best of your ability adding as many details as available. For most accurate information, the case manager or social worker should complete this section.

☐ **Budget:** The budget should be filled out as completely as possible. Billing addresses for all utilities must be changed to PO Box at time of referral/application. **Client must sign.**

☐ **Client/Agency Responsibility:** Contract describing the responsibilities of the payee. **Client must sign.**

☐ **Contract for Services:** Contract defining scope of programs and establishing voluntary participation in program(s). **Client must sign.**

☐ **Advanced Notification:** Client must sign and **original** must be mailed to the PO Box.

☐ **Physician Statement:** This is required when there was no previous payee. The **originals** must be mailed to the PO Box.

☐ **Authorization for Release of Information:** Please have this completed and **signed by the client.**

☐ **Recent Labs/Medications/Appointments:** Please include lab reports and medication lists outlining the client’s most recent viral load/CD4, most recent appointment dates, any future appointments, and medications.

☐ **Copy of Photo ID AND Insurance card:** Please include a copy of the client’s photo ID & health insurance card.

☐ **True Link Agreement:** Optional. If client elects to have TrueLink card, please send **signed agreement** with packet and give client copies of materials (ATM LOCATIONS, EXPLANATION OF USE).
AUTHORIZATION FOR RELEASE OF INFORMATION

I, hereby authorize ____________________________________________ to release information from the records of ____________________________________________ DOB: _____/_____/_____.

Only the information checked below is to be released:

☐ Psychiatric Evaluation/Summary of Hospitalization (include discharge summary)
☐ Medical/Hospitalization/Developmental/Social History
☐ Treatment Recommendations/Medications

☐ HIV Information:
  ☐ Course of Treatment ☐ Psych Evaluations ☐ Hepatitis A,B,C
  ☐ Lab Reports/Dates ☐ Case Management ☐ Medications
  ☐ Date Diagnosed ☐ CD4 Count ☐ Other____________________
  ☐ AIDS Diagnosis ☐ Medical History _______________________
  ☐ Appointments ☐ Viral Load _____________________________

PLEASE FORWARD INFORMATION TO THE ATTENTION OF:

The Open Door, Inc.
PO Box 99243, Pittsburgh, PA 15233

I have been told that, in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person or agency listed above, and will be in effect for 90 days after the date of my signature, unless specified below. I also understand that this consent is revocable expect to the extent that action has been taken in reliance thereon. This consent shall be in effect:

_______________________________
(FROM MM/DD/YYYY UNTIL MM/DD/YYYY)

_______________________________
CLIENT NAME (PRINT)

_______________________________
CLIENT SIGNATURE

_______________________________
DATE

_______________________________
STAFF MEMBER NAME (PRINT)

_______________________________
STAFF MEMBER SIGNATURE

_______________________________
DATE
CLIENT INFORMATION I

Client Name _________________________________________________________

Client Date of Birth ____________________________________________________

Client Social Security Number ____________________________________________

Client Address __________________________________________________________

Client Telephone __________________________________________________________

Client Race ______ Client Age ______ Veteran? Yes No

Recent VL ________ Date ________ Recent CD4 ________ Date ________

Ryan White Certification □ Yes □ No if Yes, eURN _________________________

Certifying Agency __________________________ Certification Expiration Date ________________

City and State of Client’s Birth ___________________________________________

Maiden Name of Client’s Mother _____________________________________________

Insurance ____________________________ SPBP enrolled (Y/N) ______________

Living Arrangement:

_____ Homeless from the Streets  _____ Homeless from Shelter  _____ Living w/ friends or relative

_____ Rental Housing  _____ Transitional Housing  _____ Jail/Prison  _____ Hospital

_____ Other: ____________________________

Date of HIV Diagnosis _________________________________________________

Transmission Factor _________________________________________________

Agency/Case Manager Name ______________________________________________

Case Manager Telephone# ________________________________________________

Case Manager Email _____________________________________________________
CLIENT INFORMATION II

Behavioral/Mental Health Illness: Please List Diagnoses:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Current or Past Drug Use: Please Explain:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Current or Past Criminal Involvement: Please Explain:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Do you receive any other income? Please Explain:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
CLIENT INFORMATION III

Eviction History (Please tell us more about housing instability. Were any funds used to avoid eviction? How much? How many times? When?):
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Utility Shut-Offs (Were funds used to avoid a shut off? How much? How many times? When?):
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Other emergency assistance client has received:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Current Medications and Dosage:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Name of Physician_______________________________________________________________
Physician Address_______________________________________________________________
Name of Dentist_________________________________________________________________
Dentist Address_________________________________________________________________
Name of Pharmacy_______________________________________________________________
Pharmacy Address_______________________________________________________________

Name of Mental Health Provider___________________________________________________

Mental Health Provider Address____________________________________________________

CLIENT INFORMATION IV

Please give a brief explanation as to why the resources of a representative payee are needed in this particular situation (Please be as specific as possible, this is needed for processing by Social Security):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Do you currently have a payee? ________________________________

If yes, please explain the reason for changing:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
CLIENT INFO V
HOUSING REFERRAL

Housing referral (Y/N)?
______________________________________________________________________________

IF YES, PLEASE COMPLETE THIS PAGE AND THE ENTIRE PACKET.

IF NO, PLEASE MOVE ON TO THE NEXT PAGE.

Please give a detailed explanation as to why supportive housing is needed in this particular situation (Please be as specific as possible):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

The entire application must be sent to:
The Open Door, Inc.
PO Box 99243
Pittsburgh, PA 15233
reppayee@opendoorhousing.org
or fax 855-862-5411
Advance Notification of Representative Payment

<table>
<thead>
<tr>
<th>Name of Wage Earner, Self-Employed Person or SSI Claimant</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Beneficiary (if other than above)</th>
<th>Relationship to Wage Earner, Self-Employed Person or SSI Claimant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

I understand and agree with the following.

Need for Representative Payee

The Social Security Administration (SSA) has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a representative payee. It is the duty of the representative payee to use my benefits for my best interests.

Choice of Representative Payee

SSA has selected THE OPEN DOOR, INC. to be my representative payee.

My Right to Appeal

I understand that I have the right to appeal SSA’s decision. I can appeal the choice of who will be the representative payee. In most cases, I can also appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in file and submit new evidence. I understand that I can have a friend, lawyer or someone else to help me.

I understand that I must file an appeal within 60 days. If I file after the 60 day period, I must have a good reason for not having filed this appeal on time. I have to ask for the appeal in writing. I will contact an SSA office if I wish to appeal.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Witnesses are required only if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness

   Address (Number and Street, City, State and ZIP Code)

2. Signature of Witness

   Address (Number and Street, City, State and ZIP Code)

Form SSA-4164 (9-1994) ef (5-2005)
Destroy Prior Editions
PHYSICIAN’S/MEDICAL OFFICER’S STATEMENT OF PATIENT’S CAPABILITY TO MANAGE BENEFITS

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA’s website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

Privacy Act Statement

Sections 205(a) and 205(j), of the Social Security Act, as amended, authorize us to collect this information. The information is needed to make a determination regarding whether or not the named individual should be paid benefits directly or whether benefits should be paid to a representative payee. The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on the proper payee for benefit receipt purposes.

We rarely use the information you supply for any purpose other than for making a determination on a claim. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to: (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person’s eligibility for Federally funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0089 and 60-0222. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

In replying, use this address:

Social Security Administration

PHONE NUMBER (Including Area Code)

DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)

If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER

PATIENT'S NAME

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

PATIENT’S SOCIAL SECURITY NUMBER

PATIENT’S DATE OF BIRTH

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations; SSA will NOT pay for this information. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

Form SSA-787 (05-2010) ef (05-2010) Destroy Prior Editions
1. Date you last examined the patient

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?
   By capable we mean that the patient:
   • Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
   • Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

   [ ] Yes
   If "Yes", please omit question 3, but be sure to sign and date the form.

   [ ] No
   If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

   [ ] Unsure
   If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

   [ ] Yes
   [ ] No

   If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)

ADDRESS (Number and street, City, State, and ZIP Code)

TELEPHONE NUMBER (Include Area Code)

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER

DATE
MONTHLY BUDGET

<table>
<thead>
<tr>
<th>INCOME</th>
<th>EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI</td>
<td>Amount</td>
</tr>
<tr>
<td>SSD</td>
<td></td>
</tr>
<tr>
<td>DPW/STATE SUPPLEMENT</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
<tr>
<td>TOTAL INCOME</td>
<td></td>
</tr>
<tr>
<td>TOTAL EXPENSES</td>
<td></td>
</tr>
<tr>
<td>PARTICIPANT SAVINGS</td>
<td></td>
</tr>
</tbody>
</table>

I request that The Open Door, Inc. makes the aforementioned payments on my behalf.

I authorize this monthly budget.

I agree to have all utility bills sent to The Open Door, Inc. PO BOX 99243 Pittsburgh, PA 15233

I understand that expenses to anyone other than myself can only be made via paper check.

PARTICIPANT SIGNATURE: ____________________________________________
CLIENT/AGENCY RESPONSIBILITY

Name ______________________________    SSN___________________________

I hereby authorize The Open Door, Inc. to manage my benefits and to serve as my organizational representative payee. I understand that the Social Security Administration (SSA) or my employer will send my benefits to my organizational representative payee. It is the duty of the representative payee to manage my benefits in my best interest with my prior knowledge and input.

I hereby acknowledge that this consent is truly voluntary.

It has been explained to me that the point of contact regarding payee budgeting, questions, and/or concerns is the case manager listed in this application.

As a client of The Open Door, Inc. Representative Payee Program, I have the right to confidential treatment of information provided to any Agency staff member. The client’s responsibility is to provide adequate, accurate information so that the agency will provide efficient service to meet client needs.

Date of Birth (_____/_____/_____)  SS#______________________________

____________________________    _____________________________
Beneficiary Signature      Date of Referral

____________________________
Beneficiary Address

Phone #
CONTRACT FOR SERVICES

I _________________________________________________, voluntarily agree to participate in housing and/or representative payee services (please circle one or both) as well as non-medical case management with The Open Door, Inc. I understand that The Open Door, Inc. is responsible for helping me with recommendations, referrals, and other services, based on my self-identified needs. The furthest this information will be transmitted is to parties for whom I have requested and given written permission to obtain my information.

I agree to be actively involved in the development and maintenance of a Service Coordination Plan that will assist me with my physical, mental, and behavioral health as well as any other needs I identify such as, housing.

I understand that The Open Door, Inc. offers the following services:

- Non-Medical Case Management: linkage with and coordination of medical, behavioral health, and supportive services; advocacy and monitoring of service plan.
- Housing: supportive, transitional housing to improve medical and medication adherence and reduce housing instability.
- Representative Payee Services: financial management of social security benefits to improve medical and medication adherence and reduce financial and housing instability.

If The Open Door, Inc. does not offer a service that I am seeking, I understand that my case manager will assist me with a referral to another agency that does provide the service.

I understand that The Open Door, Inc. respects my decisions and values, will support me in the choices I make, and I understand that I have the right to choose change or discontinue services at any time.

Client Name (print):________________________________________ Date:____________

Client Signature: __________________________________________Date:____________

CM Signature: ____________________________________________Date:____________
The True Link Card is a reloadable Visa card, which enables THE OPEN DOOR, INC. to make spending money deposits safely, quickly, and reliably. The card also allows you the freedom to purchase things that enhance your quality of life. Please read the rules below, sign the agreement, and return to:

The Open Door, Inc.
PO Box 99243, Pittsburgh, PA 15233

*WE WILL SIGN YOU UP AUTOMATICALLY. IF YOU DO NOT WISH TO HAVE A CARD AND WOULD LIKE TO CONTINUE RECEIVING CHECKS, PLEASE CONTACT YOUR SOCIAL WORKER IMMEDIATELY*

We require you to sign this Agreement with The Open Door, Inc. in order to use the True Link card.

PLEASE KNOW THIS IS NOT REQUIRED
AND WE WILL STILL WRITE CHECKS IF YOU CHOOSE!

You agree to the following:
• To not let anyone else use your card.
• That we have the right to stop the program at any time, and ask for the card to be returned.
• To a monthly TRUE LINK fee of $7 per month, that will be charged automatically every month.
• To ONLY use Allpoint ATM’s to avoid ATM fees (locations provided in packet) or get cash back when making purchases to avoid any fees at all.

FUNDING SCHEDULE
• The card will be loaded with funds on the same day we receive your benefits.
• All requests for additional funds will be processed and loaded onto your card WITHIN 1-2 BUSINESS DAYS. (ONLY 1 PER MONTH)

By signing this you understand this you agree to these terms, and that The Open Door may choose to stop using these cards at any time and you will go back to receiving spending money via checks in the mail. The undersigned agree to the rules set out in this The Open Door Agreement. If these rules are not followed or if the True Link Card is misused in any way, card privileges will be revoked.

PLEASE CHECK YES OR NO AND SIGN BELOW SIGN UP FOR A TRUE LINK CARD.
If yes, I agree to the $7 fee per month charged by True Link and paid on my behalf by The Open Door, Inc.

<table>
<thead>
<tr>
<th>YES, I WANT A TRUE LINK CARD!</th>
<th>NO, I DO NOT WANT A TRUE LINK CARD.</th>
</tr>
</thead>
</table>

_______________________________________________________
Printed Name

_______________________________________________________            ______________________
Signature            Date
Carefully review the “Explanation of Use” document with all clients who have elected to use the True Link card for their spend money.

Please make sure that the client understands the “Agreement” and signs this form. Return the signed copy to us at reppayee@opendoorhousing.org.

Please provide the client with copies of all TrueLink documents:

- All Point ATM locations
- TrueLink Agreement
- Explanation of Use
EXPLANATION OF TRUE LINK CARD USE

On the day you receive your SSI or SSDI monthly income, up to $200 of your spending money will be loaded onto the “TrueLink” VISA debit card, at 8:00am. Any additional money (over the $200) will be available at 8:00am one business day after your payday.

The TrueLink card can easily block charges, prevent fraud (by using a PIN), and save you time, money, and frustration waiting for your check to come in the mail.

How to use your “TrueLink” spending card

You can use your TrueLink card anywhere a VISA is accepted. The card is for everyday purchases, such as:

- Groceries
- Restaurants
- Online shopping
- Cash back after purchases

The TrueLink card will not:

- Let you get cash out at the bank
- Let you make purchases when there is no more money on the card
- Let you make purchases from places that you have chosen to block

How to get cash off your card

- When making an in-store purchase, select DEBIT, enter your PIN, and select CASH BACK. (There is no fee to get cash back.)
- Visit any All Point ATM to withdraw cash (There is no fee to use an All Point ATM).

How to get your card balance

You don’t need to set up a username and password to access your balance information. You will need:

- Last 4 numbers of social security number
- Date of birth
- Last 4 numbers of TRUE LINK card

**Phone:**
- Call 1-800-299-7646
- Check your balance

**Online:**
- Visit www.truelinkfinancial.com
- Click “Login.”
- Click “Sign in as Cardholder” to see your balance and recent transactions

**Text messages:**
- Call 1-800-299-7646 to add your phone number to your account profile.
- Text 1-800-299-7646 with the word “balance” to check the balance on your card

***DO NOT GET BALANCE INQUIRY AT ATM! IT WILL CHARGE YOU A FEE***
When can I expect funds on my card?

Your card will be loaded with up to $200 on the day we receive your benefits, at 8:00am. Any additional money will be available one business day later, at 8:00am.

- SSI & SSDI payment dates usually fall on the 1st and 3rd of the month, so your money would be available the same day at 8:00am.
- All requests for additional funds will be processed and loaded onto your card within 1-2 business days
- If you make a request with your social worker on a Friday, you will receive your money by Tuesday.

When should I call TrueLink, and when should I call my social worker?

Call TrueLink for anything related to your card, like:

- To get your balance of your spending money
- To change your PIN number
- For questions about charges you have made with your card
- For questions about problems with your card
- If your card is lost or stolen

Call your social worker:

- When you want additional spending money added to your card
  - Remember, there is only 1 special request per month.
- When you want to block a purchase
  - If you want to block charges from a certain bar or store, contact your social worker to add this information to your monthly budget sheet.
  - Nothing will be blocked without your permission.

What do I do if my card is lost or stolen?

Call TrueLink

- 1-800-299-7646, and report your card lost or stolen.
- The new card will be mailed to The Open Door, and then mailed to you. This may take 1-2 weeks. You may wish to receive your spending money by check if your new card does not arrive in time.
- There is a $5.00 fee for a new card.
PLEASE ONLY USE THESE
ATM LOCATION, OR ANY ALLPOINT
ATM

MOST CVS’S, 7-ELEVEN’S, &
SUNOCO’S

LOOK FOR THIS LOGO!

Allpoint

ATM LOCATION

ALL ALPOINT ATM’S

NORTHSIDE

7-ELEVEN
1001 Western Ave
Pittsburgh, PA 15233

ALLEGHENY GENERAL HOSPITAL
(main hospital)
320 E North Ave
Pittsburgh, PA 15212

TAMMYS PLACE
1354 Goettman St
Pittsburgh, PA 15212

DARBEAS TAVERN
1962 Lowrie St
Pittsburgh, PA 15212

MR JACKS NEIGHBORHOOD
3184 Mcclure Ave
Pittsburgh, PA 15212

SUNOCO
4528 Ohio River Blvd
Bellevue, PA 15202

SUNOCO
4528 Ohio River Blvd
Bellevue, PA 15202

BEN AVON MINI MART
200 Division Ave
Pittsburgh, PA 15202

7-ELEVEN
8136 Ohio River Blvd
Pittsburgh, PA 15202

MCKEES ROCKS

Sunoco
351 Stanhope St
Pittsburgh, PA 15204
WESTVIEW

**Sunoco**
5457 Perrysville Rd
Pittsburgh, PA 15229

**Kmart**
996 W View Park Dr
Pittsburgh, PA 15229

**SAMS TOBACCO BEER & POP OUTLET**
1030 W View Park Dr
Pittsburgh, PA 15229

**7-ELEVEN**
1102 Perry Hwy
Pittsburgh, PA 15237

**Drinks Bar**
348 Center Ave
Pittsburgh, PA 15229

**Rochester Road Shop N Save**
184 Rochester Rd
Pittsburgh, PA 15229

**7-Eleven**
525 Perry Hwy
West View, PA 15229

**Getgo**
5603 Babcock Blvd
Ross Township, PA 15237

MCKNIGHT ROAD

**7-Eleven**
4775 Mcknight Rd
Pittsburgh, PA 15237

**Target**
4801 Mcknight Rd
Pittsburgh, PA 15237

**Walgreens**
4885 Mcknight Rd
Pittsburgh, PA 15237

**Getgo 2**
7675 Mcknight Rd
Pittsburgh, PA 15237

DOWNTOWN

**Wyndham Grand Pittsburgh Downtown**
600 Commonwealth Pl
Pittsburgh, PA 15222

**CVS**
226 6th St
Pittsburgh, PA 15222

**7-Eleven**
601 Penn Ave
Pittsburgh, PA 15222

**7-Eleven**
643 Liberty Ave
Pittsburgh, PA 15222

**CVS**
610 Wood St
Pittsburgh, PA 15222

**CVS**
242 Fifth Ave
Pittsburgh, PA 15222

**7-Eleven**
429 Wood St
Pittsburgh, PA 15222
CVS
429 Smithfield St
Pittsburgh, PA 15222

7-Eleven
420 Smithfield St
Pittsburgh, PA 15222

Apollo Cafe
429 Forbes Ave
Pittsburgh, PA 15219

7-Eleven
1 Bigelow Sq
Pittsburgh, PA 15219

Kennys Place
1404 5th Ave
Pittsburgh, PA 15219

Washington Plaza
1420 Centre Ave
Pittsburgh, PA 15219

Rolands Seafood Grill
1904 Penn Ave
Pittsburgh, PA 15222

Club Vip II
2404 Webster Ave
Pittsburgh, PA 15219

OAKLAND/EAST PGH

CVS
3440 Forbes Ave
Pittsburgh, PA 15213

Genes Place
3616 Louisa St
Pittsburgh, PA 15213

Salem's Grill
338 S Bouquet St
Pittsburgh, PA 15213

7-Eleven
3955 Forbes Ave
Pittsburgh, PA 15213

Sunoco
195 N Craig St
Pittsburgh, PA 15213

CVS
4725 Centre Ave
Pittsburgh, PA 15213

Getgo
4924 Baum Blvd
Pittsburgh, PA 1521

Dean Of Shadyside Salon
5404 Centre Ave
Pittsburgh, PA 15232

West Penn Hospital 2
4800 Friendship Ave
Pittsburgh, PA 15224

Sunoco
4779 Liberty
Pittsburgh, PA 15224

Tobacco Outlet
4501 Liberty Ave
Pittsburgh, PA 15224

Getgo
4000 Butler St
Pittsburgh, PA 15201

Barbs Country Kitchen
4717 Butler St
Pittsburgh, PA 15201
Sunoco
5013 Butler St
Pittsburgh, PA 15201

Walgreens
5956 Penn Cir S
Pittsburgh, PA 15206

Target
6231 Penn Ave
Pittsburgh, PA 15206

CVS
6100 Penn Ave
Pittsburgh, PA 15206

Lounge 7101
7101 Frankstown Ave
Pittsburgh, PA 15208

DJs Bar & Grille
7141 Frankstown Ave
Pittsburgh, PA 15208

Rosings Lounge
7217 Frankstown Ave
Pittsburgh, PA 15208

Getgo
408 Penn Ave
Wilkinsburg, PA 15221

Kmart
1775 S Braddock Ave
Pittsburgh, PA 15218

CVS
7406 Church St
Swissvale, PA 15218

Sunoco
7403 Washington St
Swissvale, PA 15218

Ts Circus Bar
7526 Washington Ave
Pittsburgh, PA 15218

MCKEESPORT

Sunoco A Plus Mini Market
600 Lysle Blvd
Mckeesport, PA 15132

Walgreens
7628 Penn Ave
Pittsburgh, PA 15221

Sunoco
7701 Penn Ave
Pittsburgh, PA 15221

CVS
520 Penn Ave
Wilkinsburg, PA 15221

Auto Shower II
921 Pennwood Ave
Wilkinsburg, PA 15221

Hoots Again
3115 Walnut St
Mckeesport, PA 15132

Stage 1
428 N State St
Clairton, PA 15025

Getgo
2811 Jacks Run Rd
White Oaks, PA 15131