



## PROGRAM APPLICATION

P.O. Box 99243  
Pittsburgh, PA 15233

### 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).*



**The Open Door, Inc.**  
P.O. Box 99243  
Pittsburgh, PA 15233  
www.opendoorhousing.org

## 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

\_\_\_\_\_

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### PLEASE FORWARD INFORMATION TO THE ATTENTION OF:

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

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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:

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

---

CLIENT NAME (PRINT)

---

CLIENT SIGNATURE

---

DATE

---

STAFF MEMBER NAME (PRINT)

---

STAFF MEMBER SIGNATURE

---

DATE



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## 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 \_\_\_\_\_



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## CLIENT INFORMATION II

Behavioral/Mental Health Illness: Please List Diagnoses:

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Current or Past Drug Use: Please Explain:

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Current or Past Criminal Involvement: Please Explain:

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Do you receive any other income? Please Explain:

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### 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?):

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

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Other emergency assistance client has received:

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Current Medications and Dosage:

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Name of Physician \_\_\_\_\_

Physician Address \_\_\_\_\_

Name of Dentist \_\_\_\_\_

Dentist Address \_\_\_\_\_

Name of Pharmacy \_\_\_\_\_



The Open Door, Inc.  
PO Box 99243  
Pittsburgh, PA 15233  
[reppayee@opendoorhousing.org](mailto:reppayee@opendoorhousing.org)  
or fax 855-862-5411

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## Advance Notification of Representative Payment

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Name of Wage Earner, Self-Employed Person or  
SSI Claimant

Social Security Number

- -

Name of Beneficiary (if other than above)

Relationship to Wage  
Earner, Self-Employed  
Person or SSI Claimant

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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.

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Signature

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Date

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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

2. Signature of Witness

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

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



**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](http://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.**

In replying, use this address:  
SOCIAL SECURITY ADMINISTRATION

TELEPHONE 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**

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.

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

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

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)?

☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)	TITLE	
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.**

Form **SSA-787** (05-2010) ef (05-2010)

## MONTHLY BUDGET

NAME:

DATE:

INCOME	
SSI	
SSD	
DPW/STATE SUPPLEMENT	
OTHER	
TOTAL INCOME	
TOTAL EXPENSES	

PARTICIPANT SAVINGS	
---------------------	--

EXPENSES		
	Amount	Notes
RENT		
ELECTRIC		
GAS		
SPENDING MONEY		
SPENDING MONEY		
TOTAL EXPENSES		

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: \_\_\_\_\_



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### 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 #



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## 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 Open Door, Inc.  
P.O. Box 99243  
Pittsburgh, PA 15233  
[www.opendoorhousing.org](http://www.opendoorhousing.org)

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.**

YES, I WANT A TRUE LINK CARD!	NO, I DO NOT WANT A TRUE LINK CARD.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# **THE OPEN DOOR, INC.**



## **TRUE LINK CARD**

### **EXPLANATION OF USE**

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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](mailto:reppayee@opendoorhousing.org).

Please provide the client with copies of all TrueLink documents:

- All Point ATM locations
- TrueLink Agreement
- Explanation of Use



The Open Door, Inc.  
P.O. Box 99243  
Pittsburgh, PA 15233

## 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.

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### 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](http://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\*\*\***

P.O. Box 99243, Pittsburgh, PA 15233





The Open Door, Inc.  
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### 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 1<sup>st</sup> and 3<sup>rd</sup> 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.

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### 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.

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### 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!**



**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

**Salems 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

**Walgreens**

7628 Penn Ave  
Pittsburg, 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

**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

**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