CONFIDENTIAL
APPLICATION FOR APPOINTMENT TO
SACRAMENTO TRANSITIONAL GRANT AREA (TGA)

HIV Health Services Planning Council, Committees or Work Groups

Thank you for your interest in serving on the Council, or one of its Committees or Work Groups. Please fill out this application completely and return it to the Council office. Applications will be kept on file for one year from the date of submission and will be considered when filling unexpected vacancies during the year.

I. INDIVIDUAL PROFILE

A. Identification

1. Name: _____
2. Mailing Address: _____
3. City: _____ Zip: _____ County: _____
4. Contact Information: E-Mail _____

   Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

   Other: ( ) _____ Fax: ( ) _____ Other: _____
5. I am employed by: _____

   Position/Title: _____

B. Council Participation

Please mark all groups with which you are currently involved or familiar with the work of the HIV Health Services Planning Council:

_____ Council Member _____ Alternate _____ Committee Member _____ Work Group Member

_____ Interested Party *(please explain):* _____

C. Representation

Please mark any categories you are currently qualified to represent:

_____ Affected communities, including any person living with HIV/AIDS, parents/guardians of HIV infected children, caregivers of people living with HIV/AIDS, and/or historically underserved groups

_____ Community based organization serving affected populations or an AIDS service organization

_____ Health care provider and/or federally qualified health center

_____ Hospital planning or health care planning agency

_____ Local public health agency

_____ Mental health provider

_____ Non-elected community leader

_____ Provider with a history of serving children, youth and families with HIV

_____ Social service provider

_____ Housing and homeless services provider

_____ Substance abuse provider

_____ State Medicaid agency

_____ Organization with a history of serving children, youth, and families living with HIV

_____ Part C grantee

_____ Other Federal HIV programs (including AETC and HOPWA)

_____ Formerly incarcerated person living with HIV/AIDS

_____ Other (please specify): _____

II. REFLECTIVENESS

A. Demographics

The federal regulations for the structure of the HIV Health Services Planning Council require that a Council's membership reflect the current epidemic of HIV/AIDS within the TGA. The following information will be helpful in ensuring that the membership accurately reflects the requirements. The information you provide on this form will be anonymously combined with that of other Council participants in any reported information. We therefore ask that you select the categories with which you most closely identify, even if you don't use identical language in describing yourself.

1. I am: _____ Male _____ Female _____ Transgender Date of Birth: _____

2. May age group is: __ 12 or under __ 13 – 19 __ 20 – 29 __ 30 – 39 ___40 – 49 __ 50 -59 __ 60+

3. a) I self-identify as HIV positive: _____ Yes _____ No
   (Confidential disclosure is required for the application, but will not be revealed without your permission.)
   b) I am a consumer of services paid for by Ryan White CARE Act funds: _____ Yes _____ No
   c) If positive, age at diagnosis? __ 13 – 19 __ 20 – 29 __ 30 – 39 ___40 – 49 __ 50 -59 __ 60+

4. I self-identify in the following race/ethnic category:

_____ African American/Black	_____ Asian
_____ White/Caucasian (not Hispanic)	_____ Native Hawaiian/Pacific Islander
_____ American Indian/Alaska Native	_____ Latino/Hispanic

B. Interest and Advocacy

Please identify up to three areas of experience or expertise that you can contribute to Council activities.

1. <u>HIV Health needs of:</u>

_____ Gay/bisexual men	_____ Heterosexual Men
_____ Injecting drug users	_____ Substance users
_____ Women, including lesbians	_____ People in rural areas
_____ Hemophiliacs/blood transfusion recipients	_____ Infants, children, and youth
_____ People with disabilities	_____ People who are incarcerated

III. QUESTIONS

Please answer the following questions and be as specific as you can about your experience. For example: give the length of time you were involved in particular activities, state whether you have had a staff or volunteer role, etc. (Use additional pages if necessary.)

1. Why are you interested in serving on the HIV Health Services Planning Council?

2. What are your primary concerns as they relate to the HIV/AIDS epidemic and HIV/AIDS services available in the Sacramento region?

3. What experience have you had with HIV infection or AIDS in your personal or professional life?

IV. REFERENCES

List two people who may be called to verify your qualifications to be a representative on this Council. Letters of support are not required.

Name:		Name:	
Address:		Address:	
Telephone:	( )	Telephone:	( )

V. DESIRED PARTICIPATION

Please consider my application for the following positions, whenever there is an opening to be filled:

_____ Planning Council Member

_____ Planning Council Alternate (HIV+ persons only)

_____ Committee Member (please indicate which committee)

_____ Affected Communities	_____ Priorities and Allocations
_____ Governance	_____ Quality Advisory Committee
_____ Needs Assessment	_____ Work Groups (short term, throughout year)
_____ Prevention and Education	_____ African American Outreach & Prevention

_____ Any of the above for which I qualify

VI. APPLICATION PROCESS

- Assistance with completion of the application is available by calling 916-876-5548
- A personal interview may be requested as part of the application process. You will be notified if an interview is required.
- Applications will be kept on file for one year after the submittal date.
- Individuals who are appointed to membership must be willing to volunteer at least 8 hours per month to HIV Health Services Planning Council activities, including preparation and attendance at regular monthly meetings, as well as participation on at least one committee of the Planning Council. Members will be removed upon missing three consecutive regular meetings or five regular meetings within a twelve-month period.
- For additional information, call the HIV Health Services Planning Council at 916-876-5548

PLEASE SUBMIT APPLICATION TO:

Attention: Paula Gammell
HIV Health Services Planning Council
Ryan White CARE Program
9616 Micron Ave, Suite 930
Sacramento, CA 95827
Confidential Fax (916) 854-9459

I hereby certify that I have completed this application to the best of my knowledge and ability.

Signature of Applicant: _____ **Date:** _____

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