

CONFIDENTIAL
2008 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:
Home: () _____ Work: () _____ Cell: () _____
Pager: () _____ Fax: () _____ E-mail: _____
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:

<input type="checkbox"/> Council Member	<input type="checkbox"/> Alternate	<input type="checkbox"/> Committee Member	<input type="checkbox"/> Work Group Member
<input type="checkbox"/> Interested Party (<i>please explain</i>): _____			

C. Representation

Please mark any categories you are currently qualified to represent:

<input type="checkbox"/> 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	<input type="checkbox"/> Provider with a history of serving children, youth and families with HIV
<input type="checkbox"/> Community based organization serving affected populations or an AIDS service organization	<input type="checkbox"/> Social service provider
<input type="checkbox"/> Health care provider and/or federally qualified health center	<input type="checkbox"/> Housing and homeless services provider
<input type="checkbox"/> Hospital planning or health care planning agency	<input type="checkbox"/> Substance abuse provider
<input type="checkbox"/> Local public health agency	<input type="checkbox"/> State Medicaid agency
<input type="checkbox"/> Mental health provider	<input type="checkbox"/> Organization with a history of serving children, youth, and families living with HIV
<input type="checkbox"/> Non-elected community leader	<input type="checkbox"/> Title III grantee
	<input type="checkbox"/> Other Federal HIV programs (including AETC and HOPWA)
	<input type="checkbox"/> Formerly incarcerated person living with HIV/AIDS
	<input type="checkbox"/> 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
2. 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) If yes, my age at diagnosis was: 13 or under 13 – 19 20 – 44 45 or over
- c) I am a consumer of services paid for by Ryan White CARE Act funds: Yes No
3. I self-identify in the following race/ethnic category:
- | | |
|---|---|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Asian/Pacific Islander, Specify: _____ |
| <input type="checkbox"/> White/Caucasian (not Hispanic) | <input type="checkbox"/> Latino/Hispanic, Specify: _____ |
| <input type="checkbox"/> Native American/Alaskan Native | <input type="checkbox"/> Other, Specify: _____ |

B. Interest and Advocacy

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

1. HIV Health needs of:
- | | |
|--|---|
| <input type="checkbox"/> Gay/bisexual men | <input type="checkbox"/> Heterosexual Men |
| <input type="checkbox"/> Injecting drug users | <input type="checkbox"/> Substance users |
| <input type="checkbox"/> Women, including lesbians | <input type="checkbox"/> People in rural areas |
| <input type="checkbox"/> Hemophiliacs/blood transfusion recipients | <input type="checkbox"/> Infants, children, and youth |
| <input type="checkbox"/> People with disabilities | <input type="checkbox"/> 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
_____ Council Development	_____ Service Standards
_____ Governance	_____ Work Groups (short term, throughout year)
_____ Needs Assessment	
_____ Any of the above for which I qualify	

VI. APPLICATION PROCESS

- Assistance with completion of the application is available by calling 447-7063 x329
- 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) 447-7063 x329.

PLEASE SUBMIT APPLICATION TO:

HIV Health Services Planning Council
909 12th Street, Suite 200
Sacramento, CA 95814
Fax (916) 447-7052

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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