



APPLICATION FOR MEMBERSHIP 2017

Please tell us if you are applying to as a new member or if you are applying as a current member.
(Please Check One)

- NEW MEMBER** (I belong to the population for which I am providing information)
- CURRENT MEMBER**
- MEMBER AT LARGE**

SECTION 1: CONTACT INFORMATION

IF SELECTED FOR MEMBERSHIP, THIS CONTACT INFORMATION WILL BE SHARED WITH CURRENT PLANNING COUNCIL MEMBERS.

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

County: _____

Telephone: (home) _____ (office) _____ (cell) _____

E-mail: _____

Agency of Employment: _____

Many communications about meeting notices and document review are sent via email. Do you check email at least twice per week?

- Yes
- No



SECTION 2: CATEGORIES OF REPRESENTATION

The Council is required to have participants from all sectors of the epidemic. These questions help us determine whether or not we are meeting our membership goals. Please check all that apply.

Gender:

- Male
- Female
- Transgender

Age:

- under 18
- 18 - 24
- 25 or older

Race (CHECK ALL THAT APPLY):

- Black/African American
 - Asian/Pacific Islander
 - Caucasian
 - Hispanic/Latino
 - Native American/Alaskan
 - Black/African Born
 - Other, please describe:
-

Ethnicity:

- Hispanic/Latino

HIV Status

- HIV POSITIVE.
- HIV NEGATIVE
- Decline to share this information.



| SPECIALIZED EXPERIENCE | PROVIDER OF SERVICES (Check all that apply to you.) | CONSUMER OF SERVICES (Check all that apply to you.) |
|---|--|--|
| Health-care provider, including Federally Qualified Health Centers | | |
| Federally Qualified Health Centers/ Hospitals | | |
| Community-based organization serving affected populations/AIDS Service Organizations (ASOs) | | |
| Social service organizations | | |
| HOPWA | | |
| Mental health services | | |
| Substance-abuse services | | |
| Rural | | |
| Local public health agency | | |
| Hospital planning | | |
| Affected community member (either HIV community or underserved population community) | | |
| State Medicaid Program | | |
| Veteran Affairs | | |
| Ryan White Part A Program | | |
| Ryan White Part B Program | | |
| Ryan White Part C Program | | |
| Ryan White Part D Program | | |
| Social Marketing | | |
| TB, Viral Hepatitis, or STD Services | | |
| Prevention Service Provider | | |
| MSM | | |
| Perinatal –FIMR | | |
| Health Risk/Risk Reduction Education | | |
| Epidemiology | | |
| Faith Community | | |
| Program Evaluation | | |
| Organizations addressing the needs of children, youth, and families with HIV. | | |
| Other Federal HIV Program, including HIV prevention programs | | |
| Department of Corrections, Ex offender, Persons who advocate for Prisoners | | |
| Community Leader | | |
| Emerging Populations (Seniors, African immigrants, transgendered, homeless, IDU) | | |



| AGENCY REPRESENTATION | DO YOU REPRESENT ANY AGENCY (Check all that apply to you.) |
|---|--|
| Health-care provider, including Federally Qualified Health Centers | |
| Federally Qualified Health Centers/ Hospitals | |
| Community-based organization serving affected populations/AIDS Service Organizations (ASOs) | |
| Social service organizations | |
| HOPWA | |
| Mental health services | |
| Substance-abuse services | |
| Rural | |
| Local public health agency | |
| Hospital planning | |
| Affected community member (either HIV community or underserved population community) | |
| State Medicaid Program | |
| Veteran Affairs | |
| Ryan White Part A Program | |
| Ryan White Part B Program | |
| Ryan White Part C Program | |
| Ryan White Part D Program | |
| Social Marketing | |
| TB, Viral Hepatitis, or STD Services | |
| Prevention Service Provider | |
| MSM | |
| Perinatal –FIMR | |
| Health Risk/Risk Reduction Education | |
| Epidemiology | |
| Faith Community | |
| Other Federal HIV Program, including HIV prevention programs | |
| Department of Corrections, Ex offender, Persons who advocate for Prisoners | |
| Community Leader | |
| Emerging Populations | |



SECTION 3: SPECIAL INTEREST & SKILLS

What special **skills** can you bring to the Planning Council? Mark as many as apply:

| | | | |
|--|--|--|-------------------------|
| | Leadership | | Program evaluation |
| | Program planning | | Group process |
| | Budgeting/Financial management | | Needs assessment |
| | Research or technical training in HIV/AIDS | | Quality management |
| | HIV medical care | | Other, please describe: |
| | Grant writing | | |
| | Community organizing | | |

Which committees do you think you might have an interest in joining?

- Care Continuum Committee (Prevention & Care)
- Stakeholder Engagement Committee
- Comprehensive Plan Committee

Have you attended Planning Council or Planning Council committee meetings in the past?

- No
- Yes If yes, please describe your involvement: _____



I want to serve on Georgia Prevention and Care Council because:

How would your background and past experience be useful in planning for a system of prevention and/or care for those at risk of HIV infection and for people living with HIV/AIDS?



How did you hear about us?

- Georgia Department of Public Health
- Local Health Department
- CBO/ASO
- Ryan White Care Consortia
- Georgia HIV Prevention Community Planning Group
- Other:

Signature of Applicant

Date

NOTE: APPLICATIONS ARE NOT COMPLETE UNTIL YOU HAVE SIGNED THIS APPLICATION

Please call 404-651-7655 with questions. THANK YOU FOR YOUR INTEREST IN GEORGIA PREVENTION AND CARE COUNCIL.



ARE YOU INTERESTED IN JOINING THE HIV PREVENTION PROGRAM REVIEW PANEL? IF SO, PLEASE SIMPLY ANSWER THE QUESTIONS BELOW. (YES OR NO)

1. DO YOU HAVE KNOWLEDGE IN HIV/AIDS
2. DO YOU HAVE EXPERTISE WITH CULTURAL SENSITIVITY AND LANGUAGE INTENDED FOR HIV PRIORITY POPULATIONS?
3. ARE YOU A STATE OR LOCAL HEALTH DEPARTMENT EMPLOYEE?
4. DO YOU HAVE EXPERIENCE WORKING IN ACADEMIA AND/ OR SCHOOL BASED POPULATIONS?

IF SELECTED, YOU WILL BE CONTACTED BY: CICELY RICHARD.