

PORTLAND AREA HIV SERVICES PLANNING COUNCIL

MEMBERSHIP APPLICATION

Thank you very much for your interest in Council membership. If you have questions, please contact the Council office at (503) 988-3030 ext. 25703.

Planning Council meetings are generally held once a quarter, though more often when necessary. Regular meetings are held on the first Wednesday of the month. Committee meetings are arranged to meet the schedules of those participating.

Section 1: APPLICANT INFORMATION

Please print the following information clearly:

Name: _____ County: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No. (home) _____ (work) _____ (cell) _____

E-mail: _____ Fax: (only if confidential) _____

Mailing Address (if different than above): _____

Preferred method of contact: Email Mail; Phone (# _____);

Emergency Contact Name: _____ Phone: _____

Primary Language: _____ If not English, would you like a translator? Yes No

The federally authorized Ryan White Program requires that the Planning Council be reflective of the local HIV/AIDS epidemic. For this purpose, please identify any or all of the following categories that apply to you.

Gender: Male Female Transgender

Age: Under 18 18-24 25-49 50 and above

Date of birth: _____
(optional but helpful for statistical purposes)

Ethnicity/Race:

- | | |
|---|---|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Multiracial (describe) |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Hispanic/Latino/Latina | |

Optional: The Bylaws of the Planning council require that no less than 33% of its members be persons living with HIV (PLWH), and that at least two of these members must be living with HIV and be willing to sign a release allowing public identification of their HIV status. (Please note that this information is made public for only two persons on the Council: Council Co-Chair and Nominations Co-Chair. Other persons may disclose their status at his or her own discretion.)

If you are a person living with HIV/AIDS, are you willing to identify yourself as such?

- Yes No Not applicable

If you are a person living with Hepatitis B or Hepatitis C, are willing to identify yourself as such?

- Yes No Not applicable

Section 2: EXPERIENCE WITH HIV/AIDS

Please describe why you are interested in serving on the HIV Services Planning Council (50 words or less):

Have you ever worked or volunteered at an agency or organization which provides services to people with HIV/AIDS?

- Yes No

If yes, please list the agencies/organizations where you have worked/volunteered and describe your position:

Agency	Job Description

Have you participated in health-related advisory groups, boards or task forces?

- Yes No

If yes, please list the groups and describe your involvement:

Group	Involvement

Does your current employer/organization receive any Ryan White funding?

- Yes No

If yes, please explain: _____

Section 3: SPECIAL INTERESTS & SKILLS

Please check any special or professional skills that you can bring to the Planning Council:

- | | | |
|---|---|---|
| <input type="checkbox"/> community organizing | <input type="checkbox"/> group process/facilitation | <input type="checkbox"/> legal expertise |
| <input type="checkbox"/> health policy | <input type="checkbox"/> needs assessment | <input type="checkbox"/> program development |
| <input type="checkbox"/> public relations | <input type="checkbox"/> team work | <input type="checkbox"/> program evaluation |
| <input type="checkbox"/> advocacy | <input type="checkbox"/> public speaking | <input type="checkbox"/> research or technical training |

Other (please describe) _____

**Interested in
learning more about**

**Able to provide
information about**

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | case management |
| <input type="checkbox"/> | <input type="checkbox"/> | food/nutrition |
| <input type="checkbox"/> | <input type="checkbox"/> | health care planning |
| <input type="checkbox"/> | <input type="checkbox"/> | home health care |
| <input type="checkbox"/> | <input type="checkbox"/> | housing |
| <input type="checkbox"/> | <input type="checkbox"/> | mental health treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | outreach |
| <input type="checkbox"/> | <input type="checkbox"/> | prevention |
| <input type="checkbox"/> | <input type="checkbox"/> | primary health care |
| <input type="checkbox"/> | <input type="checkbox"/> | public health |
| <input type="checkbox"/> | <input type="checkbox"/> | services for persons with chronic illness and/or disabilities |
| <input type="checkbox"/> | <input type="checkbox"/> | service needs for the end of life |
| <input type="checkbox"/> | <input type="checkbox"/> | social services planning |
| <input type="checkbox"/> | <input type="checkbox"/> | social support |
| <input type="checkbox"/> | <input type="checkbox"/> | substance abuse treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | transportation |
| <input type="checkbox"/> | <input type="checkbox"/> | health care needs of communities of color |
| <input type="checkbox"/> | <input type="checkbox"/> | health care needs of injecting drug users |
| <input type="checkbox"/> | <input type="checkbox"/> | rural health care needs |
| <input type="checkbox"/> | <input type="checkbox"/> | health care needs of children |
| <input type="checkbox"/> | <input type="checkbox"/> | health care needs of women |
| <input type="checkbox"/> | <input type="checkbox"/> | health care needs of gay/bisexual men |
| <input type="checkbox"/> | <input type="checkbox"/> | other (please describe: |

Section 4: Membership Representation

The Planning Council is required to have representation from the following categories. Please mark all that you feel you are able to fill.

- Health Care provider, including federally qualified health centers
- Community-based organizations serving affected populations/AIDS Service Organizations
- Social service providers, including providers of housing and homeless services
- Mental health provider
- Substance abuse provider
- Local public health agency
- Hospital planning agency or health care planning agency
- Affected communities, including people living with HIV/AIDS, members of a federally recognized Indian tribe as represented by the population, individuals co-infected with hepatitis B or C and historically underserved groups and subpopulations
- Non-elected community leader
- State Medicaid agency
- State Part B agency
- Part C
- Part D, or, if none are operating in the area, representatives of organizations addressing the needs of children, youth, women, and families living with HIV
- Other Federal HIV programs, including HIV prevention programs
- Representative of/or formerly incarcerated PLWH/A

I understand that the information I have provided on this form is confidential. By signing this application, I understand this information will be available to the Nominations Committee for review.

Signature of Applicant

Date

Please return the completed original application and a signed *Conflict of Interest Disclosure* form to:

Portland Area HIV Services Planning Council
SE Health Center
3653 SE 34th Avenue
Portland, OR 97202

(503) 988-3030 ext. 25703 or 25681

www.hivportland.org

The Planning Council accepts applications for membership at any time with membership two-year terms beginning in September. Applications are considered to fill interim-term vacancies as they arise. Applications are valid for one year from the date they are received.