

**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:

<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 (please explain): _____			

**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"/> Community based organization serving affected populations or an AIDS service organization <input type="checkbox"/> Health care provider and/or federally qualified health center <input type="checkbox"/> Hospital planning or health care planning agency <input type="checkbox"/> Local public health agency <input type="checkbox"/> Mental health provider <input type="checkbox"/> Non-elected community leader	<input type="checkbox"/> Provider with a history of serving children, youth and families with HIV <input type="checkbox"/> Social service provider <input type="checkbox"/> Housing and homeless services provider <input type="checkbox"/> Substance abuse provider <input type="checkbox"/> State Medicaid agency <input type="checkbox"/> Transgender communities <input type="checkbox"/> Organization with a history of serving children, youth, and families living with HIV <input type="checkbox"/> Part C 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): _____
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## 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:  M to F  F to M  
Additional Gender Identity: \_\_\_\_\_ Year of Birth \_\_\_\_\_
2. My age group is:  12 or under  13 - 24  25 - 34  35 - 44  45 - 54  55 - 64  65+
3. I self-identify in the following race/ethnic category:  
 African American/Black  Asian  White/Caucasian (not Hispanic)  
 American Indian/Alaska Native  Latinx/Hispanic  Native Hawaiian/Pacific Islander
4. 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 positive, I am a consumer of services paid for by Ryan White CARE Act funds:  Yes  No  
c) If positive, age at diagnosis?  12 or under  13 - 19  20 - 29  30 - 39  40 - 49  50 - 59  60+  
d) If positive, exposure category:  Men who have Sex with Men (MSM)  Intravenous Drug User (IDU)  
 MSM/IDU  Heterosexual  Other (Unknown/Hemophilia/Perinatal/Blood Exposure)

### 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 who are transgender                | <input type="checkbox"/> People who are incarcerated  |
| <input type="checkbox"/> People with disabilities                  |                                                       |

## 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)
_____ Administrative Assessment	
_____ Any of the above for which I qualify	

**VI. APPLICATION PROCESS**

- Assistance with completion of the application is available by emailing HIV-HSPC@saccounty.gov
- 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 who miss three consecutive regular meetings or five regular meetings within a twelve-month period will have their membership reviewed.
- For additional information, please email HIV-HSPC@saccounty.gov

PLEASE SUBMIT APPLICATION TO:  
 Sacramento HIV Care Services Program  
 9616 Micron Ave, STE. 930  
 Sacramento, CA 95827  
 or email to  
 HIV-HSPC@saccounty.gov

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

<b>Signature of Applicant:</b> _____	<b>Date:</b> _____
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