

**SAN ANTONIO EMA HIV HEALTH SERVICES PLANNING COUNCIL
APPLICATION FORM**

NOTE: The information you provide on this form is "PUBLIC INFORMATION".

Name: _____
(First) (Middle Initial) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ FAX: _____ Email: _____

Employer: _____ Position: _____ Length of employment: _____

Address: _____
(Street) (City) (State) (Zip)

Gender: Male Female Other: _____

Ethnicity: White/Anglo Hispanic/Latino Black/African-American

Asian/Pacific Islander Native American Other: _____

Applying for: Membership Alternate: _____ Advisor
Member's Name

Please indicate the area the individual represents (check only **ONE**):

- 1. Health Care Provider, including Federally Qualified Health Centers
- 2. Community Based-Organizations and AIDS Service Organizations serving the affected populations
- 3. Social Service/Housing/Homeless Provider
- 4. Mental Health Provider*
- 5. Substance Abuse Provider*
- 6. Local Public Health Agency
- 7. Hospital Planning Agencies or Health Care Planning Agencies
- 8. Affected Communities, including individuals with HIV disease or AIDS and historically underserved groups and sub-populations: willing to at least acknowledge HIV status to the Planning Council. (Including a person released within the last three years from a correctional facility or an individual providing direct client services to persons in a correctional facility.)
- 9. Non-Elected Community Leader
- 10. State Medicaid Agency[#]
- 11. Ryan White CARE Act Title II[#]
- 12. Ryan White CARE Act Title IIIb Grantees
- 13. Ryan White CARE Act Title IV
- 14. Other Federal HIV Programs: Ryan White CARE Part F HOPWA Other: _____
- 15. HIV Prevention

* A single person may represent both the Mental Health Provider and the Substance Abuse Provider

[#] A single person may represent both the CARE Act-Title II grantee and the State Medicaid Agency

Do you have any special needs in considering applying for membership to the HIV Health Services Planning Council (i.e., transportation, meals, or other needs: _____)

1. List any training, experience, qualifications, special interests or expertise relevant to serving on the HIV Health Service Planning Council, including membership in any organization(s) focusing on HIV issues.

2. Volunteer Activities/Community Service – Include current/past involvement on boards, planning groups, or organizations. Identify any office or seat held.

3. **Rules of law and ethics prohibit members from participating in and voting on matters in which they may have a direct/indirect financial interest.** Are you aware of any potential Conflicts of Interest (i.e., are you or a significant other a member of, employee of, or have a direct/indirect financial interest in an organization seeking/receiving Ryan White CARE Act Title I funds?)

4. Recognizing the Boards and Commissions are often demanding on one's time and schedule, are you committed to attending the regularly scheduled Planning Council meetings. Are you willing to accept any work assignments, which require **a minimum of 10 hours per month?**
 Yes No

5. What Planning Council committee(s) would you like to serve on?

<input type="checkbox"/> Comprehensive Plan/ Continuum of Care	<input type="checkbox"/> Service Allocations & Evaluations	<input type="checkbox"/> Case Management
<input type="checkbox"/> Needs Assessment/ Priority Setting	<input type="checkbox"/> Membership/ Nominations/Elections	<input type="checkbox"/> People's Caucus

Please return this application and resume (optional) to:

San Antonio Area HIV Health Services Planning Council
233 N. Pecos, Suite 590
San Antonio, Texas 78201

For information, call (210) 212-7508 or send an email to rrecio@bexar.org.

Applicant's Signature: _____ Date

Planning Council Member's Signature: _____ Date
(This signature is needed if the applicant is applying as an alternate)