MEMBERSHIP APPLICATION

If you are interested in serving on the HPC, please complete the attached application and return it to Attention: Donald Wood, via email at dwood@capconsc.com, via mail at Capitol Consultants, PO Box 1763, Columbia, SC 29202, or via fax at 803-252-0589. Please print legibly or type.

All information provided in this application will be kept CONFIDENTIAL.

South Carolina HIV Planning Council
MEMBERSHIP APPLICATION

Name: ____________________

Date of Birth (month/day/year): ____________________

HOME CONTACT INFORMATION

Home Mailing Address: ____________________

City, State, Zip Code: ____________________

County of Residence: ____________________

Home Telephone Number: (   ) ____________________

Alternate Phone (cell/other): (________) ____________________

Home Fax Number: (   ) ____________________

Home E-mail Address: ____________________

WORK CONTACT INFORMATION

❑ NOT APPLICABLE

Agency/Organization: ____________________

Mailing Address: ____________________

City, State, Zip Code ____________________

Counties served: ____________________

____

Work Telephone Number: (   ) ____________________

Work Fax Number: (   ) ____________________

Work E-mail Address: ____________________

Person to Contact in Case of Emergency:

Name: ____________________ Relationship: ____________________

Phone Numbers: ____________________

Education:

Name and Location of School	Highest Education Level Achieved (Diploma, Certificate, Degree)	Major/Minor
Example: Eau Claire High School Columbia, SC	Diploma	College Prep

1. **GENDER (Select one):**
   - ❑ Female
   - ❑ Male
   - ❑ Transgender/Intersexed

2. **ETHNICITY (Select one):**
   - ❑ Hispanic/Latino
   - ❑ Non-Hispanic/Latino

3. **RACE (Select one):**
   - ❑ More Than One Race
   - ❑ Black or African American
   - ❑ American Indian/Alaska Native
   - ❑ Asian
   - ❑ Native Hawaiian or Pacific Islander
   - ❑ White or Caucasian
   - ❑ Other (Please specify):____

4. **REPRESENTATION OF SEXUAL ORIENTATION, HIV EXPOSURE RISK and STATUS: (Confidential)**

   We ask you to divulge your Sexual Orientation, HIV Exposure Risk and HIV Status as that information is shared by category (no individual identifiers) to ensure representation of all populations. Membership representation including Sexual Orientation, HIV Exposure Risk and HIV status are required to be reported to the CDC by member with no other identifying information.

   A. My Sexual Orientation
   - ❑ Heterosexual
   - ❑ Bisexual
   - ❑ Homosexual/Gay
   - ❑ Other (Please specify): ____

   B. My HIV Exposure Risk Category (Select one answer that best describes your risk)):
   - ❑ Man who has Sex with Men (MSM)
   - ❑ High Risk Heterosexual (HRH)
   - ❑ Injecting Drug User (IDU)
   - ❑ MSM/IDU
   - ❑ HRH/IDU
   - ❑ Perinatal (exposure/infection as a result of my mother having HIV)
   - ❑ Other (please specify): ____
   - ❑ No Identified Risk

C. My HIV Status (Select one):

__________ Positive
__________ Negative
__________ Unknown/Unsure

5. A and B. Please place a <u>"1" in one box below that best describes your primary role or area of expertise</u>, and a <u>"2" in one box that describes your secondary role or area of expertise</u>:

Professional and Community Representation	Area of Expertise
Health Department HIV/AIDS staff	
Health Department STD/STI staff	
Health Department Viral Hepatitis staff	
Health Department Tuberculosis staff	
Health Department Epidemiologist	
Other health department staff (specify):	
Non-Health Department Staff:	
Health or health services researchers	
Program evaluators	
Behavioral or social scientists	
Representatives of the substance abuse community	
Representatives of the mental health community	
Representatives of the education community	
Representatives of the corrections/criminal justice community	
Medical doctors	
Staff from Ryan White HIV Care and Support Services	
Staff from Substance Abuse Provider	
Staff from community-based HIV prevention agencies	
Staff from community-based social service agencies (includes services for homeless persons, veterans, sexual assault victims, etc.)	
Faith leaders	
Community members interested in or affected by HIV/AIDS	
Other:	

VI.A. Preferred Choice of Committee

From the three standing committees of the HIV Planning Council with open membership, please rank order your choice of committees on which you wish to serve (1 being most desired, 3 being least desired). Please note some committees meet more than others and you are expected to attend all meetings.

_____ Care and Support Services
_____ Needs Assessment
_____ Prevention

VI.B. Positive Advocacy Committee

If you are a person living with HIV/AIDS, are you interested in serving on the Positive Advocacy Committee (which meets on separate meeting days from the HIV Planning Council)? Please check one:

__________ Yes   __________ No   __________ N/A

VII. Skills and Experience

From the list of HIV-related services listed below, please check all that you have experience in providing.

____ Advocacy
____ Case Management
____ Clinical Care
____ Counseling and Testing
____ Health Education/Risk Reduction
____ Housing
____ Mental Health Services
____ Outreach
____ Partner Services
____ Substance Abuse Services
____ Other (please specify): ____

____

QUESTIONS

1. Why are you seeking membership on the SC HIV Planning Council? What do you have to offer as a member of the Planning Council?

2. Briefly describe your involvement working with HIV prevention and/or care in your local community. **[If you are a staff member of an organization involved in HIV/STD prevention and/or care, please include a copy of your resume or curriculum vita (CV).]**

3. What boards, task forces, and other planning or community groups do you serve on or represent?

4. Please provide the contact information for three (3) people who can affirm the information you have provided.

   Name # 1____

   Title: ____

   Agency/Organization: ____

   Mailing Address: ____

   ____

   Daytime Phone Number:____

   Name # 2 ____

   Title: ____

   Agency/Organization: ____

   Mailing Address: ____

   ____

   Daytime Phone Number: ____

   Name # 3____

   Title: ____

   Agency/Organization: ____

   Mailing Address: ____

   ____

   Daytime Phone Number: ____

________ (initial) I have read the commitment requirements and responsibilities for the SC HIV Planning Council and am able to fulfill these requirements and responsibilities if I am selected. I understand that the commitment is for a specified term which requires attendance at all HPC meetings and active participation in Standing Committee meetings and conference calls.

________ (initial) I understand, affirm, and agree that all statements on this form are true and accurate and that any misrepresentation or omission of facts may result in my being disqualified for membership on the SC HIV Planning Council.

____

Signature Date

Signature of Parent/Guardian (if under 18 years of age) ____