

# Indiana Comprehensive HIV Services Planning and Advisory Council (Advisory Council) Membership Application

Please use this form to apply for membership on the Indiana Comprehensive HIV Service Planning and Advisory Council. All information on this form will be used only for the purpose of selecting a balanced group membership and will be held as confidential.

## Section I: Applicant Information

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Place a check-mark by your **preferred** contact number.

- Daytime Phone \_\_\_\_\_  
 Evening Phone \_\_\_\_\_  
 E-Mail \_\_\_\_\_  
 Fax Machine \_\_\_\_\_

Is it okay to leave a discreet message at your **preferred** number?

- Yes  No

**Why do you ask?** Demographic information is required to ensure the Indiana Comprehensive Planning and Advisory Council membership reflects the diversity and demographics of the HIV epidemic in Indiana. Please choose the following answers that describe your gender, race, spoken language, and educational background.



### PRIMARY LANGUAGE

- English  Spanish  American Sign Language  Other

### SECONDARY LANGUAGE

- English  Spanish  American Sign Language  Other

### SEX

- Male  Female  Transgendered

### RACIAL/ETHNIC BACKGROUND

- White (not Hispanic)  Hispanic  Asian/Pacific Islander  Other  
 Black (not Hispanic)  Multi-Racial  Native Am./Alaskan Native

### EDUCATIONAL BACKGROUND (mark only the last level of education completed)

- Middle School (or less)  Vocational/Technical Training  Bachelor's Degree  
 Some High School  Some College  Graduate (or higher) Degree  
 High School/GED  Associate's Degree

### TRANSPORTATION AND SPECIAL CONSIDERATIONS (mark all areas that apply)

- I own a car  My medication requires refrigeration  I take the bus  
 Others provide my transportation  I need other special accommodations  I need help reading

### SPECIAL SKILLS (mark all areas in which you have specialized knowledge or skills)

- Addictions  Blindness  Communications  Deafness  Education  Employment  
 Families  Housing  Insurance  Literacy  Mental Health  Transportation

## Section II: Applicant Experiences, Skills, and Interests

Describe any beneficial experiences that you may have had working with city or state governments.

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What other experience, talents, or expertise will you be able to bring to the Comprehensive HIV Services Planning and Advisory Council?

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Are you affiliated with any ISDH-funded providers or grantees? If so, please indicate these below. Also, indicate any other potential conflicts of interest.

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**Which description best represents you?** (mark only one)

- Person living with HIV
- Parent of a minor who is HIV+
- Legal guardian of a person who is HIV+
- HIV Service Provider
- Other Type of Provider
- Member of the Public



Please use the space below to provide any other pertinent information you would like to share.

## Section III: Membership Representation

The Advisory Council is comprised of members experienced in the delivery or receipt of HIV-related health and human services. It consists of no more than forty-nine (49) voting members. The Advisory Council strives to have its membership composition reflect the demographics of the HIV epidemic in Indiana. A minimum of 33% of the members are expected to be individuals infected with HIV. The Advisory Council membership matrix includes the twenty-one specific representational categories delineated below. Any one member's characteristics may not satisfy more than one category.

### Check the category which you feel you best represent (mark only one)

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Representative from HIV Care Coordination           <ul style="list-style-type: none"> <li><input type="checkbox"/> Region 1</li> <li><input type="checkbox"/> Region 2</li> <li><input type="checkbox"/> Region 3</li> <li><input type="checkbox"/> Region 4</li> <li><input type="checkbox"/> Region 5</li> <li><input type="checkbox"/> Region 6</li> <li><input type="checkbox"/> Region 7</li> <li><input type="checkbox"/> Region 8</li> <li><input type="checkbox"/> Region 9</li> <li><input type="checkbox"/> Region 10</li> <li><input type="checkbox"/> Region 11</li> <li><input type="checkbox"/> Region 12</li> </ul> </li> <br/> <li><input type="checkbox"/> Representative from geographic area with the more than 500 living HIV cases           <ul style="list-style-type: none"> <li><input type="checkbox"/> Region 1</li> <li><input type="checkbox"/> Region 2</li> <li><input type="checkbox"/> Region 3</li> <li><input type="checkbox"/> Region 6</li> <li><input type="checkbox"/> Region 7</li> </ul> </li> <br/> <li><input type="checkbox"/> Affected community member, including historically underserved groups           <ul style="list-style-type: none"> <li><input type="checkbox"/> Non-whites</li> <li><input type="checkbox"/> Injection drug user (past or present)</li> <li><input type="checkbox"/> Females</li> </ul> </li> <br/> <li><input type="checkbox"/> Pharmacist providing services to PLWH</li> <br/> <li><input type="checkbox"/> Community-based or other organization member</li> <br/> <li><input type="checkbox"/> Community Planning Group or other community member</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Consumer Representative           <ul style="list-style-type: none"> <li><input type="checkbox"/> Northern Area (multi-region)</li> <li><input type="checkbox"/> Region 1</li> <li><input type="checkbox"/> Region 2</li> <li><input type="checkbox"/> Region 3</li> <li><input type="checkbox"/> Central Area (multi-region)</li> <li><input type="checkbox"/> Region 4</li> <li><input type="checkbox"/> Region 5</li> <li><input type="checkbox"/> Region 6</li> <li><input type="checkbox"/> Region 7</li> <li><input type="checkbox"/> Region 8</li> <li><input type="checkbox"/> Southern Area (multi-region)</li> <li><input type="checkbox"/> Region 9</li> <li><input type="checkbox"/> Region 10</li> <li><input type="checkbox"/> Region 11</li> <li><input type="checkbox"/> Region 12</li> </ul> </li> <br/> <li><input type="checkbox"/> HOPWA administration representative</li> <br/> <li><input type="checkbox"/> Other Federal HIV grantee (Part A-F)           <ul style="list-style-type: none"> <li><input type="checkbox"/> Part A</li> <li><input type="checkbox"/> Part C - North</li> <li><input type="checkbox"/> Part C - Central</li> <li><input type="checkbox"/> Part C - South</li> <li><input type="checkbox"/> Part F</li> </ul> </li> <br/> <li><input type="checkbox"/> Mental health services provider</li> <br/> <li><input type="checkbox"/> Substance abuse services provider</li> <br/> <li><input type="checkbox"/> Primary care physician or nurse practitioner providing services to PLWH</li> </ul> |
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### If seeking to serve in a non-voting technical assistance capacity, check the category you best represent (mark only one)

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Infectious disease physician or nurse practitioner</li> <li><input type="checkbox"/> Office of Medicaid Policy and Planning</li> <li><input type="checkbox"/> Office of Family Social Services Administration</li> <li><input type="checkbox"/> Dentist providing services to PLWH</li> <li><input type="checkbox"/> Hospital or health advisory agency</li> <li><input type="checkbox"/> Legal services provider to PLWH</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Representative from philanthropic institutions with a history of grant-making for HIV-related care and treatment services</li> <li><input type="checkbox"/> Federally-Qualified Healthcare Centers</li> <li><input type="checkbox"/> Other</li> </ul> |
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## Section IV: Applicant Signature

*Please feel free to attach additional pages to further address any of the questions on this form. Letters of reference are also accepted in support of this application.*

By signing below, I certify that I understand that, if selected to be a member of the Comprehensive HIV Services Planning and Advisory Council, I may have access to information of a highly sensitive nature. Examples of this include, but are not limited to, the HIV status and sexual orientation of other persons, specific service utilization data from other persons or agencies, and sensitive financial information. I understand that all information must be treated as completely confidential.

Further, I realize that unauthorized disclosure of confidential information may have serious legal consequences and constitutes grounds for immediate removal from the Council and that my obligation to maintain confidentiality will not expire with termination of service.

### SIGN AND DATE HERE

\_\_\_\_\_  
Name of applicant (please print)

\_\_\_\_\_  
Daytime phone number

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date of this application



*The overall Mission of the Indiana Comprehensive Services Planning and Advisory is to work in partnership with the Indiana State Department of Health (ISDH). Jointly, the Advisory Council and ISDH share the mission of assuring HIV positive individuals and their families access to a comprehensive network of high quality care and treatment services. The Advisory Council is organized and will be operated exclusively for the purpose of advising in the planning and development of a continuum of high quality, culturally sensitive, cost effective, client centered healthcare and support service for persons with HIV disease and their families. Moreover, the Advisory Council shall efficiently respond to the changing face of the epidemic with regards to all affected sub-population and impacted regions within the state regardless of sexual orientation, gender, race, ethnic origin, disabilities, religious beliefs, lifestyles or manner in which infection was contracted.*