

Seattle TGA HIV Planning Council Membership Application

Name: _____

Mailing Address: _____ City: _____ ZIP _____

Home Address: _____ City: _____ ZIP _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____
 Preferred # Preferred # Preferred #

Email: _____ County of Residence: King Island Snohomish Other: _____

Are you be available to interview after a Council meeting (2nd Monday, from 4:00-6:30pm)? Yes No

If not, please check which days of the week and times of the day you would you be available for an interview:

MON AM PM TUE AM PM WED AM PM THUR AM PM FRI AM PM

Applications are considered based on *identified gaps in representation on the Planning Council.*

**All applicants must attend a Council meeting before their application will be considered.
 Please call 206-263-2030 for Council meeting dates, times and locations.**

1. Please describe your personal and/or professional experience and expertise related to HIV disease or with the system of HIV/AIDS care services or related activities.

2. Please discuss your interest in serving on the Planning Council and what skills or perspective would you bring to the Planning Council to strengthen its effectiveness?

3. How long have you lived in the Seattle Transitional Grant Area (King, Snohomish & Island counties)?

4. What else would you like us to know about you?

I have read the two page "What Can I Expect in a Term on the Planning Council." I am willing to commit the time and effort required of Planning Council Members should I be selected for service.

Signature: _____ Date: _____

Please check the slots you fill, and include additional information as indicated

✓	Mandated Representational Slot Please check to the left if you fill this representational category
	Person Living with HIV who is “unaligned” <input type="checkbox"/> I receive services related to my HIV (for information, call Council staff, below). <input type="checkbox"/> I do not work and am not a paid consultant at a Ryan White Part A funded agency. <input type="checkbox"/> I am not on the board of directors of an agency that receives Ryan White Part A funding.
	Medical provider to PLWH Number of PLWH on my current caseload: _____ Name of clinic or practice _____
	Direct service provider in an AIDS Services Organization Name of agency: _____
	Housing/homeless services provider Name of agency: _____
	Mental health services provider
	Substance use treatment provider
	Local public health
	Non-elected community leader
	Hospital/Health planner: Name of hospital: _____
	Ryan White Part B Grantee (State DOH)
	Ryan White Part C Grantee <input type="checkbox"/> Harborview Madison Clinic <input type="checkbox"/> Country Doctor Community Clinic
	Ryan White Part D Sub-Grantee, or provider to women, infants, children and youth with HIV Name of agency: _____
	State Medicaid Agency Representative
	Other Federal HIV Funding (AETC, SPNS, HOPWA, etc.)
	Recently Incarcerated (in last 3 years) PLWH/A or their representative
	Prevention Provider

If you have questions about any of these, please contact Planning Council staff at 206-263-2028 or 206-263-2030.

