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| West Central Florida Ryan White Care Council Application |  |

## Contact Information

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| Name |  |
| Street Address |  |
| City ST ZIP Code |  |
| Home/Cell Phone |  |
| Work Phone |  |
| E-Mail Address |  |

## Demographics

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| Care Council composition must reflect the demographics of the HIV/AIDS epidemic and include representation from federally mandated categories. **Your responses will be kept CONFIDENTIAL** and will be available only to the authorized Council support staff, Recipient and Lead Agency. (check all that apply) *\*Please note this is requirement for Health Service and Resource Administration (HRSA) Reporting, all information reported is confidential.* | | | | | | | | |
| Date of Birth: \_\_/\_\_/\_\_ | | |  | | | | | |
| Gender: |  |  | |  | |  | | |
| Black (not-Hispanic) | | | Asian/Pacific Islander | | | | Multi-Racial | |
| White (not-Hispanic) | | | American Indian/Alaskan Native | | | | Hispanic | |
| Other Please Specify: | | | | | | | | |
|  | | | | | | | | |
| I: do self-identify as a person living with HIV/AIDS  do not self-identify as a person living with HIV/AIDS | | | | | | | | |
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| Have you ever been convicted of any felonies or violent crimes?  (If Yes, please explain. Convictions will *not* disqualify you from membership. You may omit minor traffic violations and any offense committed as a minor.)   |  | | --- | |  | | | | | | | | | |

## Category of Representation

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| Ryan White HIV/AIDS Program mandated membership category or categories that I am qualified to represent: *(Check as many as appropriate)*  Individuals living with HIV or AIDS  Non-elected community leader  Underserved populations (people of color, migrant workers, women, homeless)  Representatives of/or formerly-incarcerated PLWH |
| Healthcare providers, including Federally Qualified Health Centers |
| Community Based Organization (CBO) serving underserved populations/AIDS Service  Organization (ASO) |
| Social Service Provider, including housing and homeless services provider |
| Mental Health Provider |
| Substance Abuse Provider |
| Local Public Health Agency |
| Hospital or other healthcare planning agency |
| State Medicaid Agency  Ryan White State Part B Agency  Ryan White Part C  Ryan White Part D or organizations addressing the needs of children, youth, and families with  HIV  Recipients of other federal HIV programs such as HIV Prevention programs, AETC *(AIDS*  *Education and Training Center)*, Dental, SPNS *(Special Projects of National Significance)*, and HOPWA *(Housing Opportunities for Persons with AIDS)* |
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| Personal Motivation for Membership  |  | | --- | | Please elaborate on your personal motivation/interest in obtaining voting membership for the Ryan White Care Council: | |

## Areas of Expertise

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| Please list any areas of expertise that you can bring to the Care Council: *(Special skills, knowledge, training, life experiences, volunteer experiences, boards or commissions, especially those focusing on HIV issues)* |

## Participation Agreement

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| **Active member participation is vital to the Care Council.** You are committing to attend an orientation, monthly Care Council meetings, and biannual leadership trainings. Check below if you are willing to commit the 3**-4 hours per month** required to fully participate in the planning process? **(Please initial in the box next to your selected checked box)**  Yes  Not at this time |

## Potential Conflict of interest

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

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## Thank You!

Please mail or fax the completed form to:

Suncoast Health Council

Attention: Katie Scussel

9500 Koger Blvd., Suite 102

St. Petersburg, FL 33702

Fax # (727) 570-3033