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| West Central FloridaRyan 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:      |
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| 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.)

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## 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

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| Please elaborate on your personal motivation/interest in obtaining voting membership for the Ryan White Care Council:   |

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## 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