INLAND EMPIRE HIV PLANNING COUNCIL

3041 N Sierra Way, San Bernardino, CA 92405
(909) 229-4399
www.iehpc.org

Comprising Riverside and San Bernardino Counties, California

INLAND EMPIRE HIV PLANNING COUNCIL
MEMBERSHIP APPLICATION

Residing within RIVERSIDE or SAN BERNARDINO COUNTY is a Legislative Requirement.

About the Inland Empire HIV Planning Council: The Inland Empire HIV Planning Council is a federally mandated community group appointed by the San Bernardino County Board of Supervisors to plan the organization and delivery of Ryan White HIV/AIDS Treatment Modernization Act CARE Act Part A HIV Services. Participation by community members is an integral part of the planning process for Ryan White HIV/AIDS Treatment Modernization Act Part A programs. Council meetings are held quarterly, in different regions of the two-county area. Committee meetings are held separately.

Part A funds go to Transitional Grant Areas (TGAs) that have been hit hardest by the HIV epidemic. Part A funds are used to meet the emergency service needs of people living with HIV disease that are not met by any other health care programs.

The Mission of the Inland Empire HIV Planning Council: To maintain the optimum health of all those living with HIV/AIDS in Riverside and San Bernardino Counties through the development and implementation of a comprehensive, consumer-centered continuum of care.

Applicant Name	Employer Name (if applicable)
Date of Birth	
	Employer Address
Home Address	
	City/State/Zip
City/State/Zip	
Telephone:	**Telephone:**
Home: ( ) _____	Business: ( ) _____
Cell: ( ) _____	Other: ( ) _____
Other: ( ) _____	FAX: ( ) _____
EMAIL Address:	EMAIL Address:

Convictions:

As an adult (age 18) have you ever been convicted of, or pled guilty or no contest to, a misdemeanor or felony? Do not include: (1) any convictions for possession of marijuana (except for convictions for possession of marijuana on school grounds or possession of concentrated cannabis) that are more than two years old; or (2) any information concerning a referral to and participation in, any pretrial or post trial diversion program.

[ ] No [ ] Yes If yes, please provide the following for each incident:

Date of Conviction	Location	Penal Code Section	Explanation (Attach a Separate Sheet if Necessary)

Please be aware that the Planning Council is a public body. While your HIV status will be kept confidential, membership on the council is not. You will receive mail and phone calls from the HIV/AIDS Branch and members of the Inland Empire HIV Planning Council. Would you prefer to receive phone calls, messages, and/or mail at home or at work?

I prefer to receive phone calls and messages at Home Work (circle one)
I prefer to receive mail at Home Work (circle one)

All Information provided is CONFIDENTIAL

Date Application Received: _____

PLEASE READ AND SIGN THIS SECTION

Statement of Member Commitment

If selected as a member of the Planning Council, I commit to the following:
Check off each statement to show your commitment

_____ I confirm that, to the best of my ability, I am able to attend the regularly scheduled quarterly Planning Council meetings (from 12:30pm – 3:30pm). I will notify Planning Council Support Staff in advance if I am unable to attend a meeting. **[If you are unable to attend the Planning Council meeting on a regular basis, you cannot be considered for Planning Council membership.]**

_____ I confirm that, to the best of my ability, I am able to meet the committee attendance requirement found within the IEHPC Bylaws Article V, Section 4. **[If you are unable to attend Planning Council committee meetings on a regular basis, you cannot be considered for Planning Council membership.]**

_____ I understand that membership on the Planning Council is a three-year commitment. I have considered my personal and professional commitments and do not foresee them as a barrier to my full participation on the Planning Council.

_____ I agree to abide by the Bylaws and Policies & Procedures of the Planning Council.

_____ I agree to participate in Planning Council functions and activities from call to order to adjournment.

_____ I understand I will need to prepare for meetings by carefully reading all distributed materials.

_____ When I make recommendations and decisions, I agree to consider the HIV community as a whole, rather than just special interests or personal perspectives.

_____ I agree to represent the Planning Council at community events and/or meetings periodically within the TGA.

_____ I agree to disclose any conflicts of interest I may have relative to any issues that come before the Planning Council and/or its Committees.

_____ I certify that all statements and representations made in this application are true and correct to the best of my knowledge.

_____ _____

Signature Date

Date Application Received: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS. USE ADDITIONAL SHEET(S) IF NECESSARY. ADD COMMENTS IF APPROPRIATE.

1) I am interested in serving on the Inland Empire HIV Planning Council for the following reasons (please include any beneficial experience working with or advocating for the HIV/AIDS community, any experience you have had in community planning and/or programming for HIV/AIDS related services, and what you hope to accomplish by serving on the Planning Council):

2) Active member participation is vital to the work of the Council. The Council typically requires one three-hour quarterly meeting. Additionally, much of the Council's work is accomplished by member participation in committees and/or other activities that require at least one additional two-hour quarterly meeting. These meetings rotate throughout the Riverside and San Bernardino Counties. Please tell us about your ability to attend monthly meetings and to be involved actively between meetings.

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The Perspectives Checklist will be used to determine the appropriate membership category for you to fulfill on the Council and its committees, and also to ensure compliance of the numerous legislatively mandated categories. Qualified candidates will be considered for nomination/approval and have approvals forwarded to the County Board of Supervisors, upon the availability of vacant mandated membership slots. Please circle the personal and professional perspectives that you would bring to the Council, if selected. Your personal information is confidential and will not be publicized without your consent. Persons living with HIV are encouraged to apply. If you are HIV+ and DO NOT wish to represent this community, DO NOT circle the HIV perspective.

PERSPECTIVES CHECKLIST

Please check all of the personal and professional perspectives that apply to you. Your disclosure of personal information is confidential.

GENDER IDENTITY (check one)			
	Male		Transgender
	Female		Transsexual
			Other (specify)_____
SERVICES **(Have you received services within the last six (6) months from any of the following providers?)** **(check all that apply)**			
	AIDS Healthcare Foundation (AHF)		San Bernardino County Dept. of Public Health
	Desert AIDS Project (DAP)		Riverside County Dept. of Public Health
	Foothill AIDS Project (FAP)		Riverside County Dept. of Public Health – Pharmacy
	SAC Health Systems		
	Other: _____		No, I do not receive services from any of the above listed providers.
HIV/AIDS STATUS **(check all that apply)**			
	HIV Positive, non AIDS: Age at Diagnosis _____ years		AIDS: Age at Diagnosis_____ years
	HIV Negative		Unknown

If you have self-identified as being HIV+ for the purposes of this Council, do we have your Permission to use your name and status publicly for Council purposes?
*(**Please check box and initial if applicable**)*____☐

CULTURAL / ETHNIC GROUP **(Check all that apply)**			
	African American-not Hispanic (specify)		Pacific Islander (specify)
	Asian (specify)		White – not Hispanic (specify)
	Latino/a /Hispanic (specify)		Other (specify)
	Native American/Alaskan Native (specify)		

PLEASE SELECT ALL HRSA REQUIRED CATEGORIES YOU ARE QUALIFIED AND WILLING TO REPRESENT

Date Application Received: _____

- ☐ Health Care Providers, including Federally Qualified Health Centers
- ☐ Community Based Organizations (CBOs) serving affected populations/AIDS Service Organization
- ☐ Social Service Provider, including housing and homeless service provider
- ☐ Mental Health Provider
- ☐ Substance Abuse Provider
- ☐ Local Public Health Agency
- ☐ Hospital planning agency or health care planning agency
- ☐ Affected communities, including PLWH/A and historically underserved subpopulations
- ☐ Non-elected community leader
- ☐ State Medicaid Agency
- ☐ State Part B (formerly Title II) Agency
- ☐ Part C (formerly Title III) Agency
- ☐ Part D grantees, of if none present, representatives of an organization addressing the needs of children, youth, and families with HIV
- ☐ Other Federal HIV Programs, including HIV Prevention programs
- ☐ Representative of/or PLWH/A who were formerly Federal, State or local prisoners that were released from custody the preceding three years and had HIV disease as of the date of release
- ☐ PLWH/A co-infected with Hepatitis B or C
- ☐ Representative of a local Federally recognized Native American Tribe

Please describe below how you qualify for the category/ies marked:

_____

_____

_____

I understand that the San Bernardino County Board of Supervisors makes appointments to the Planning Council with the expectation of up to a three-year commitment. Membership requires participation in the Council, and its committees, as specified in the bylaws and policies and procedures of the Inland Empire HIV Planning Council. You may be assigned to a committee at the time you are qualified as an applicant, based on your expertise and the perspectives shown on this application. You will be assigned a mentor to assist you in your Council activities. We strongly encourage you to become involved in committee work immediately, as this will assist you in familiarizing yourself with the operations of the Council.

Printed Name: _____ Signature: _____

City of Residence: _____ Date: _____

~~City of Employment (if applicable~~): _____

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL COUNCIL SUPPORT STAFF AT: 1-909 229-4399

Please return this form to:
Inland Empire HIV Planning Council
3041 N Sierra Way
San Bernardino, CA 92405

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