



Application for Reappointment

Directions: Please complete this form, and sign the Statement of Member Commitment. Return the completed form to:

Planning Council Support
301 West Jefferson Street
STE 3200
Phoenix AZ 85003
Fax: 602 506-6300

All information provided is confidential.

Terms for Planning Council members are for three years. There are no term limits, but reacceptance is based on demonstrated service and commitment to the Planning Council and is not automatic. The reappointment recommendation also requires the approval of the full Planning Council and the Board of Supervisors (BOS).

All PC members who desire to be reappointed for membership must also arrange for an evaluation interview. Please call Planning Council Support at 602 506-6321 to schedule this interview.

Personal Information *(please print)*

Name: _____

Please update your contact information:

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Home phone: _____

Alternate phone: _____

Preferred way to be contacted between 9:00 am and 5:00 pm?

Home Phone Alternate Phone Email

Birthday (month/day only): _____ / _____

PLEASE READ AND SIGN THIS SECTION

Statement of Member Commitment

If reappointed 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 monthly Planning Council meeting (currently the second Thursday of each month, from 5:00 pm to 6:30 pm). I will notify Planning Council Support in advance if I am unable to a meeting. **If you are not able to attend the monthly Council meeting 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, policies and procedures of the Planning Council.
- I agree to participate in Planning Council functions from beginning to adjournment.
- I understand I will need to prepare for meetings by carefully reading all pre-distributed materials.
- When I make recommendations and/or decisions, I agree to consider the HIV community as a whole, rather than just special interests or my personal perspectives.
- I agree to disclose any conflicts of interest I may have relative to issues that come before the Council and/or Committees.
- I certify that all statements and representations made in this application are true and correct.

Signature

Date

The Reappointment Process

- Complete this form, and be sure to sign the Statement of Member Commitment on page 1.
- Planning Council Support will review your form to ensure it is complete. We will contact you to confirm we have received it, and arrange to schedule a reappointment interview.
- This interview will be conducted by a panel of at least three members from the Membership Committee, using a standardized interview and rating process with clearly defined selection criteria.
- The interview will include a series of open-ended questions that are individually ranked by panel members on the following scale: 0 (not meet requirements), 1 (meets requirements), or 2 (exceeds requirements). Your answers on this form and your attendance at Council meetings and events will also be considered.
- The interview is an opportunity for the member to express her/his goals and suggestions for improvement of the Planning Council. It is an open dialogue where barriers to participation can be discussed freely. Training needs and other opportunities will also be discussed.
- After the interview, scores will be totaled. In order to be recommended for reappointment, a member must have an average score at the “Meets requirements” level.
- Recommendations for reappointment will be based upon the following criteria:
 - The current composition of the Council, and the level of compliance with HRSA requirements for representation and reflectiveness;
 - The individual’s level of participation, and the overall contribution to the Planning Council and its committees; and
 - The availability of potential Planning Council members from various other sources within the EMA.

Please Note: If you are applying as the representative of an organization, you will be asked to provide a written confirmation, on original company letterhead, that the organization has granted you permission to participate on their behalf. All information in this application is kept confidential. It is seen only by the Planning Council Support staff and, as needed, by members of the Membership Committee and/or the Executive Committee during the application selection process.

Please describe a positive experience you have had as a Council member: _____

Please describe a negative experience you have had as a Council member: _____

How do you feel you have contributed to the overall success of the Planning Council?

Describe your knowledge of The Ryan White Treatment Modernization Act:

- Like more training Knowledgeable
 Somewhat familiar Very knowledgeable

Describe your knowledge of the Planning Council’s Bylaws, and other policies and procedures:

- Like more training Knowledgeable
 Somewhat familiar Very knowledgeable

Describe your knowledge of the roles and responsibilities of Planning Council members:

- Like more training Knowledgeable
 Somewhat familiar Very knowledgeable

What other training opportunities interest you?

Describe why you wish to be reappointed to the Ryan White Planning Council for another three-year term:

Additional comments: _____

Please update the following information:

Gender:

- Female
 Male
 Transgendered
 Other

HIV status:

- Positive
 Negative
 Prefer not to specify
 Unknown

Current age:

- 13 to 19 years 45+ years
 20 to 44 years Prefer not to specify

Race/Ethnicity:

- White, not Hispanic
 Black, not Hispanic
 Asian/Pacific Islander
 Hispanic
 American Indian/Alaska Native
 Multi-race (more than one)
 Choose not to specify
 Other: _____

Have you received Ryan White Part A funded services within the last six (6) months?

- Yes,** I've received Ryan White Part A funded services from: *Check ALL that apply*
 - McDowell Clinic
 - Public Health Pharmacy (ADAP)
 - Ryan White Part A Dental Program
 - An HIV/AIDS service organization
 - Legal services (HIV/AIDS Law Project)
 - Food box or group meal program
 - Behavioral health program
 - Case management
 - Choose not to specify
 - Other: _____
- Maybe**—I'm not sure I've received Ryan White Part A funded services.
- No.** I do not receive Ryan White Part A funded services.

If you are not HIV positive, does HIV directly affect you (for instance, do you have an HIV positive family member/significant other, or are you the caregiver of someone living with HIV)?

- Yes No

Do you speak English? Yes Some No

Do you speak Spanish? Yes Some No

Do you speak any other language(s)? Yes No

If yes, what other language(s) do you speak?

Are you currently a volunteer at: Check ALL that apply

- An HIV/AIDS service organization, community-based organization, or any other organization that serves the HIV/AIDS community
- An organization that does not serve the HIV/AIDS community

If yes to any of the above, what organization(s)?

Do you identify as any of the following:

Check ALL that apply

- A paid employee for an HIV/AIDS service organization, community-based organization, or any other organization that serves the HIV/AIDS community
- A Board member, or emeritus Board member, of an HIV/AIDS service organization, community-based organization, or any other organization that serves the HIV/AIDS community
- A consultant (full or part-time) of an HIV/AIDS service organization, community-based organization, or any other organization that serves the HIV/AIDS community
- Having a financial interest in an HIV/AIDS service organization, community-based organization, or any other organization that serves the HIV/AIDS community

If yes to any of the above, what organization(s)?

OPTIONAL: Do you identify as belonging to any of the following groups? Check ALL that apply

- Heterosexual persons
- Gay, Lesbian or Bisexual persons
- HIV positive persons co-infected with hepatitis B or C
- Persons with hemophilia
- Injection drug users
- Parents/guardians of HIV positive children

Which membership categories do you represent?

Check ALL that apply

General Public (a representative of our community)

- Affected communities, including persons living with HIV and historically underserved populations
- Persons with HIV disease or AIDS who have been incarcerated within the last three (3) years, or their representatives
- Non-elected community leader
- Elected leader of a local municipality

Service Provider (providing Ryan White Part A funded services)

Organization Name: _____

- Health care providers, including Federally qualified health centers
- HIV/AIDS service organization, or community based organization serving affected populations
- Social service providers, including providers of housing and homeless services
- Mental health providers
- Substance abuse providers
- Local public health agencies
- Grantees under other Federal HIV programs, including HIV prevention programs
- Pinal County Health Department

Institutional Member (representing any other organization)

Organization Name: _____

- AHCCCS
- Part B Part C Part D
- Local medical organizations
- Local social service organization
- Hospital/health care planning agencies
- Primary or secondary educational institution, or university
- Other: _____

Can we assist you with any special accommodation (such as transportation assistance, wheelchair accessibility, or translation services) to help you participate fully on the Planning Council?

- No
- Yes. I need assistance with:
