



Orientation Date: \_\_\_\_\_

# CONTRA COSTA HIV/AIDS CONSORTIUM MEMBERSHIP APPLICATION

Received \_\_\_\_\_ Reviewed \_\_\_\_\_

Recommend \_\_\_\_\_ Approved \_\_\_\_\_

The Consortium is dedicated to representing the demographics of the HIV/AIDS affected community and those at greatest risk for HIV in Contra Costa County. Please print or type the following information.

## DEMOGRAPHIC INFORMATION

Name		
Mailing Address		
City	State	Zip Code

## CONTACT INFORMATION

Work Phone: _____	Cell: _____
Home Phone: _____	Pager: _____
Fax: _____	E-mail: _____

Please select the appropriate choice below.

### Where do you live?

- East Contra Costa County
- West Contra Costa County
- Central Contra Costa County
- Outside Contra Costa County:  
\_\_\_\_\_

### Ethnicity and Race

- African American
- Asian American
- European American
- Hispanic/Latino American
- Native American
- Pacific Islander American
- Other \_\_\_\_\_

### Self-identified HIV Positive

- Yes
- No

### Are you willing to disclose as HIV+

- Yes
- No

### Gender

- Male
- Female
- Transgender

### Sexual Orientation

- Bisexual
- Gay/Lesbian
- Heterosexual
- Queer

**Conflict of Interest:** A conflict of interest is defined as an interest by a Consortium member, which may result in personal, organizational, or professional gain. All members must complete a California State Form 700, Statement of Economic Interests. All conflicts of interests will be disclosed in a matrix and made available to Consortium members during allocations.

**Agency Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Affiliation:**

- Paid position - employee
- Client
- Board Member
- Volunteer – how many hours weekly? \_\_\_\_\_

**Which of the categories do you think you represent? Please select no more than three categories.**

- Infected/Affected Community\*
- Community-Based Organizations serving affected populations/AIDS Service Organizations
- Community-Based Organization providing HIV prevention services
- Health Care Provider or Federally Qualified Health Center
- Hospital or Health Care Planning Agencies
- HIV Prevention Provider
- Local Public Health Agencies
- Mental Health Provider
- Non-elected Community Leaders
- Representative of/or Formerly Incarcerated PLWH
- Social Service Provider (including housing & homeless service providers)
- Substance Abuse Services Providers
- Other (please describe) \_\_\_\_\_

\*The TGA Planning Council per HRSA stipulates that disclosure is required to be considered affected community. PLWH/A Members who are affiliated with a Service Provider agency cannot be considered affected community.

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**Would you willing to serve in a leadership role as a co-chair? \_\_\_\_\_ Yes \_\_\_\_\_ No**

**Are you interested in participating in a committee/ volunteering:** Please rank your preferences (ie., 1,2,3)

\_\_\_\_\_ Speaker’s Bureau

\_\_\_\_\_ Materials Review Panel

\_\_\_\_\_ Planning Council (Oakland TGA)

\_\_\_\_\_ Allocations (Ad Hoc: Meetings April-July)

\_\_\_\_\_ Executive Committee

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I have read the attached description of the Consortium and the roles and responsibilities of members. I understand that members, except PLWH/A, cannot send substitutes to act or vote on their behalf, that all Consortium meetings are public, and that only active Consortium members can vote.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please return your completed application to:**

**Pamela Anderson-Moore Contra Costa Public Health, AIDS Program 597 Center Avenue, Suite 200, Martinez, CA 94553 Fax: 925-313-6798 [panderso@hsd.cccounty.us](mailto:panderso@hsd.cccounty.us)**

**Thank you for your interest in the Contra Costa HIV/AIDS Consortium.**

October 3, 2012 Revised