



Membership Application

NAME

ADDRESS

CITY STATE ZIP

HOME PHONE CELL PHONE WORK PHONE

EMAIL

PREFERRED METHOD OF CONTACT: PHONE TEXT EMAIL

COUNTY OF RESIDENCE: KING SNOHOMISH ISLAND OTHER

Please indicate all days/times you are available for an interview:

MONDAY: MORNING AFTERNOON EVENING

TUESDAY: MORNING AFTERNOON EVENING

WEDNESDAY: MORNING AFTERNOON EVENING

THURSDAY: MORNING AFTERNOON EVENING

FRIDAY: MORNING AFTERNOON EVENING

**All applicants must attend a Council meeting before their application will be considered.
Please call 206-263-2030 for Council meeting dates, times and locations.**

1. Please describe your personal and/or professional experience and expertise related to HIV or with the system of HIV/AIDS care services or other related activities.

2. Please discuss your interest in serving on the Planning Council and what skills or perspective would you bring?

3. How long have you lived in the Seattle Transitional Grant Area (King, Snohomish & Island counties)?

4. What else would you like us to know about you?

I have read the two page "What Can I Expect in a Term on the Planning Council." I am willing to commit the time and effort required of Planning Council Members should I be selected for service.

Signature: Date:
(Typed name is acceptable)

MANDATED REPRESENTATIONAL POSITIONS

Please indicate all positions you are eligible to fill, and include additional information as indicated

Please check the slots you fill, and include additional information as indicated

✓	<p>Mandated Representational Positions</p> <p>Please check to the left if you fill this representational category</p>
	<p>Unaligned Consumer of Ryan White Part A services</p> <p><input type="checkbox"/> I receive Part A funded services related to my HIV (for information, call Council staff).</p> <p><input type="checkbox"/> I do not work and am not a paid consultant at a Ryan White Part A funded agency.</p> <p><input type="checkbox"/> I am not on the board of directors of an agency that receives Ryan White Part A funding.</p>
	<p>Health Care Provider to PLWH</p> <p>Number of PLWH patients on my current caseload: _____</p> <p>Name of clinic or practice _____</p>
	<p>Community Based Organization or AIDS Services Organization</p> <p>Name of agency: _____</p>
	<p>Housing/homeless services provider</p> <p>Name of agency: _____</p>
	<p>Mental health services provider</p>
	<p>Substance use treatment provider</p>
	<p>Local public health</p>
	<p>Non-elected community leader</p>
	<p>Hospital/Health planner:</p> <p>Name of hospital: _____</p>
	<p>Ryan White Part B Grantee (State DOH)</p>
	<p>Ryan White Part C Grantee</p> <p><input type="checkbox"/> Harborview Madison Clinic <input type="checkbox"/> Country Doctor Community Clinic</p>
	<p>Ryan White Part D Sub-Grantee, or provider to women, infants, children and youth with HIV</p> <p>Name of agency: _____</p>
	<p>State Medicaid Agency Representative</p>
	<p>Grantees of other Federal HIV Funding (AETC, SPNS, HOPWA, etc.)</p>
	<p>Representative of recently incarcerated PLWH</p>

If you have questions about any of these, please contact Planning Council staff at (206) 263-3017 or kchung@kingcounty.gov.

