

HIV Planning Group (HPG) Membership Application

Application Instructions/Information
<ul style="list-style-type: none"> Applications are accepted on a rolling basis throughout the year. The HPG will appoint new members annually for a three-year term, beginning on January 1st (or as needed). The HPG represents a diverse community of individuals throughout the Commonwealth of Pennsylvania who have been affected by HIV/AIDS. Applicants are asked to provide personal, experiential, and demographic information to help the HPG best reflect communities impacted by the epidemic and achieve the Group's vision, mission, and values.

Applicant Information		
Full Name:		
Home Address:		
City:	State:	Zip Code:
Primary Phone:		Secondary Phone:
E-mail:		
Employer:		
Work Address:		
City:	State:	Zip Code:
Emergency Contact Information		
Name of Person to Contact:		
Relationship to Applicant:		
Primary Phone:		Secondary Phone:
E-mail:		
Area Representation		
<p>The geographic location best describing where you live (choose one):</p> <p><input type="checkbox"/> I live in a rural area or rural community (population roughly less than 2,500)</p> <p><input type="checkbox"/> I live in a small or mid-size city. (population less than 100,000). Examples include Harrisburg, Johnstown, Scranton, Lancaster, etc.</p> <p><input type="checkbox"/> I live in a suburban area - a residential area around or just outside a larger city.</p> <p><input type="checkbox"/> I live in the city of Erie, Pittsburgh, Philadelphia, or Reading.</p> <p>My county: _____</p>		

Group Participation		
Do you currently participate, or have you participated in, any other community advisory groups? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what group/s? _____		
Demographic Information		
Age: <input type="checkbox"/> <13 <input type="checkbox"/> 14-19 <input type="checkbox"/> 20-29 <input type="checkbox"/> 30-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50-59 <input type="checkbox"/> 60+	Current Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="checkbox"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Decline to answer	What sex were you assigned at birth on your original birth certificate? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to answer
Sexual Orientation: <input type="checkbox"/> Lesbian, gay or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else (please specify): _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to disclose	Ethnicity (choose one): <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to disclose	Race (choose one): <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> More than one Race <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Prefer not to disclose

Community Representation and Work Affiliation (check all that apply):	
<p>Community Representation (groups with whom you identify):</p> <ul style="list-style-type: none"> <input type="checkbox"/> PLWH (persons living with HIV) <input type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Individuals who identify as transgender <input type="checkbox"/> Persons who inject drugs (PWID) <input type="checkbox"/> Individuals at risk through unsafe sex <input type="checkbox"/> People experiencing or who have experienced homelessness <input type="checkbox"/> People experiencing or who have experienced incarceration <input type="checkbox"/> Persons with disabilities (aging-related, mental, communicative, physical, etc.) living with or at risk for HIV <input type="checkbox"/> Emerging communities (specify): _____ 	<p>Work Affiliation:</p> <ul style="list-style-type: none"> <input type="checkbox"/> RW Part B Service Provider <input type="checkbox"/> RW Part B sub-recipient <input type="checkbox"/> RW Part C <input type="checkbox"/> Other HIV Medical Provider or Community Group <input type="checkbox"/> RW Part D <input type="checkbox"/> HIV Testing/Prevention <input type="checkbox"/> County/Municipal Health Department <input type="checkbox"/> Other specify): _____
<p>From the above Community Representation and Work Affiliation choices, indicate the ONE Community Representation or Work Affiliation that you identify with most:</p> <p style="text-align: center;">_____</p> <p>From the above Community Representation and Work Affiliation choices, indicate the second-best Community Representation or Work Affiliation that you identify with:</p> <p style="text-align: center;">_____</p>	

**Describe how the HIV epidemic has personally affected you
(use additional paper if necessary)**

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Please note that all demographic information and community representation will be kept confidential and will only be used to ensure that the HPG is choosing members that will fulfill the organization's vision, mission and values. You may be asked to provide one or two references that are knowledgeable regarding your affiliations, expertise, and/or community representation.

By signing below, I indicate my willingness and interest in becoming a member of the HPG and that the information included in this application has been provided to the best of my knowledge. I authorize verification of the information provided on this form as it pertains to my affiliations and expertise.

Name: _____

Date: _____

Signature: _____