HIV Health Services Planning Council
Middlesex - Somerset - Hunterdon

Application for Membership

About the Planning Council

The Middlesex-Somerset-Hunterdon Transitional Grant Area Ryan White Part A HIV Health Services Planning Council is a federally mandated community group appointed by the Freeholders of Middlesex County, New Jersey to plan the organization and delivery of Ryan White Part A HIV/AIDS services.

Part A funds go to Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA) that have been hit hardest by the HIV/AIDS epidemic. Part A funds are used to meet the health service needs of people living with HIV/AIDS that are not met by any other health care programs.

The goal of the HIV Health Services Planning Council is to create a seamless continuum of care that addresses the unmet needs of the infected and affected populations of the area. This is conducted through its needs assessment and planning processes and through the allocation of funding to core and support service categories. The Middlesex-Somerset-Hunterdon TGA serves a multi-county region in central New Jersey.

The following standing committees support the work of the Planning Council. They are each tasked with specific deliverables, which are reviewed and approved by the Planning Council. In addition to the efforts of the Council as a whole, members of the Planning Council are expected to serve on at least one (1) committee. These committees are:

Membership-By-Laws Committee - responsible for the recruitment and orientation of new members; annual nominations process for new officers; volunteer recognition events, develops policies for grievances; develops and revises bylaws as needed

Priorities/Comprehensive Care Plan/ Standards of Care Committee -identifies gaps in services for those infected/affected by HIV/AIDS; creates a comprehensive care plan for HIV services in region; develops standards of care for all services; recommends service category funding priorities and resource allocation percentages

'Our Voices' Client Caucus - made up of infected and affected persons; addresses concerns and needs of HIV community and presents findings to Planning Council

Administrative Assessment and Evaluation Committee -evaluates the efficiency of the administrative agent in disbursing funds; evaluates effectiveness of service delivery models

Early Identification of Individuals with HIV/AIDS Committee - identifying strategies to increase the number of individuals identified and connected to care as well as work with target high risk populations to encourage testing and prevention education

The Application Process

Please complete the following application (pages 3-8) and be sure to sign the Statement of Commitment on page 8. Return the completed form to:

Planning Council Support
Institute for Families, School of Social Work
55 Commercial Avenue, Room 314
New Brunswick, NJ 08901
T:848-932-0530
F:732-932-1798

Once your application is received, your application will be reviewed to ensure it is complete. You will be contacted to confirm that we have received it.

The Membership Committee reviews all applications and each applicant with a completed application will be scheduled for a brief interview. The Membership Committee will recommend a slate of Nominees and present the slate to the entire Planning Council for approval. A list of Nominees that represent each of the required categories and adequately reflects the demographics of the epidemic will then be recommended to the Freeholder Director of Middlesex County for appointment to the Planning Council.

Those individuals appointed by the Freeholder Director of Middlesex County to the Planning Council will have full membership and voting rights. They must complete the required New Member Orientation within six months of their appointment.

If your application is not selected for Planning Council membership, your information will be kept on file and considered in the event that a vacancy becomes available. In the meantime, we encourage you to take part in any Planning Council and/or Committee meetings, as they are open to the public.

If you have any questions or need more information please contact Natalie Aloyets Artel, Ryan White Planning Council Staff Support at:

Email:naartel@ssw.rutgers.edu Phone: 848-932-0530 Fax: 732-932-1798
Address: 55 Commercial Avenue, Room 314 New Brunswick, NJ 08901

THANK YOU FOR YOUR INTEREST IN THE
HIV HEALTH SERVICES PLANNING COUNCIL!

For Office Use Only
Date Received: _____ Date Receipt Letter:_____ Date Reviewed:_____
Interview Scheduled: __Yes __No Date Interviewed: _____ Date of Interview Notification_____
Date of Follow-up Letter_____

Middlesex-Somerset-Hunterdon HIV Health Services Planning Council Application for Membership

Statement of Confidentiality
To the greatest extent possible, all information that is provided in this application will be kept confidential. It will be viewed by the Grantee, Ryan White Program Staff, and the Membership Committee of the Planning Council as needed during the nomination/selection process.

Directions: Please read this packet carefully and complete all information clearly typed or written in black ink.

Contact Information (please print)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Email: _____

Home Phone: ( ) _____ Work Phone ( ) _____

Cell Phone: ( ) _____ Fax: ( ) _____

Please note with a (*) which number is best to reach you between 8am- 5pm Monday – Friday

Birthday (month/day only): _____/_____

May we add you to our mailing list? Yes _____ No _____

Employer: _____

Job Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Applicant Information

The Council must report certain information about the makeup of the membership. Please check all that apply to you and for which you self identify.

Have you been the recipient of Ryan White Part A services within the past 6 months?

- ○ Yes
- ○ No

Gender:

- ○ Female
- ○ Male
- ○ Transgender

Age:

- ○ 13-19 years
- ○ 20-44 years
- ○ 45 and older

Race:

- ○ White, not Hispanic
- ○ Black, not Hispanic
- ○ Hispanic
- ○ Asian/ Pacific Islander
- ○ American Indian
- ○ Alaska Native
- ○ Multi-racial

Other: _____

Other:

- ○ Person who is HIV+ or living with AIDS
- ○ Man who Has Sex with Men
- ○ Recovering Substance Abuser/User
- ○ Parent/Guardian of HIV Infected child(ren)
- ○ Formerly Incarcerated and Released Within the Past Three Years

YES, I have received Ryan White Part A Services from the following providers ***(check all that apply):***

- ☐ Central Jersey Legal Services
- ☐ Elijah's Promise Inc.
- ☐ Eric B. Chandler Health Center
- ☐ Hyacinth AIDS Foundation
- ☐ Making It Possible to End Homelessness (MIPH)
- ☐ Middlesex County Transportation
- ☐ New Brunswick Counseling Center
- ☐ Raritan Bay Medical Center
- ☐ George J. Otlowski Sr. Center for Mental Health Care
- ☐ Robert Wood Johnson AIDS Program
- ☐ Robert Wood Johnson Hospital Dental Program
- ☐ Robert Wood Johnson University Hospital - Somerset
- ☐ Somerset Treatment Services
- ☐ Visiting Nurse Association of Central New Jersey

_____

- ☐ NO, I do not receive Ryan White Part A Services.
- ☐ I don't know if I receive Ryan White Part A Services

Are you currently an **EMPLOYEE, BOARD MEMBER, PAID CONSULTANT or UNPAID VOLUNTEER** at any of the above Ryan White funded providers?

- ☐ Yes
- ☐ No

If YES, then please state the Agency/s Name and Nature of Relationship below:

_____

_____

Do you speak English?

- ☐ Yes
- ☐ No
- ☐ Some

Do you speak Spanish?

- ☐ Yes
- ☐ No
- ☐ Some

Is there any special assistance/accommodation (such as transportation, childcare, translation, wheelchair accessibility, etc.) that we might provide that would help you to fully participate in the activities of the Planning Council?

- ☐ **No**
- ☐ **Yes**. I need assistance with:

_____
_____

Special Skills/ Abilities:

_____
_____
_____
_____

Please explain why you would like to become a member of the Planning Council:

_____
_____
_____
_____
_____

Please describe any work and/or volunteer experiences you have had in HIV/AIDS service provision and/or advocacy.

_____
_____
_____
_____

Please explain how your background and past experiences would be useful in planning for a system of care for people living with HIV/AIDS.

_____
_____
_____
_____

Is there anything about you that may help us determine your eligibility for Planning Council?

_____
_____

The Planning Council by mandate of the Ryan White Act HIV/AIDS Treatment Extension Act of 2009 must include persons representing specific membership categories. Please check all categories of which you are qualified to represent:

- ○ Health Care Providers, Including Federally Qualified Health Centers
- ○ Community Based Organizations Serving HIV/AIDS populations
- ○ AIDS Service Organizations
- ○ Social Service Providers (Housing & Homeless)
- ○ Other Social Service Providers
- ○ Mental Health Provider
- ○ Substance Abuse Provider
- ○ Local Public Health Agencies
- ○ Hospital or Other Health Care Planning Agencies
- ○ Affected Communities, Including Persons Living with HIV/AIDS and Historically Underserved Populations
- ○ Non-Elected Community Leader
- ○ State Medicaid Agency
- ○ State Ryan White Part B Agency
- ○ Ryan White Part C Grantee
- ○ Ryan White Part D Grantee, or Other Organization Addressing the Needs of Children/Youth, and Families with HIV
- ○ Grantees of Other Federal HIV Programs, Including HIV Prevention programs
- ○ Formerly Incarcerated Persons with HIV/AIDS, or Their Representative

Do you have experience or interest in any of the following? (Please check all that apply):

- ○ Health Care needs of Men Who Have Sex with Men
- ○ Physically/Mentally Challenged Person
- ○ Women's HIV/AIDS Health Needs
- ○ Other Non Medical Support Services
- ○ Children's HIV/AIDS Health Needs
- ○ General Public Health Care
- ○ Youth HIV/AIDS Health Needs
- ○ Outpatient Primary Medical Care
- ○ Health Care Needs of Injecting Drug Users
- ○ Antiretroviral Therapies
- ○ Rural Health Care Needs
- ○ Comprehensive Planning
- ○ Immigrants and Refugees
- ○ Evaluation and Assessment
- ○ African American Issues
- ○ Mental Health Services
- ○ Latino/ Hispanic Issues
- ○ Substance Abuse/Use Services
- ○ Other: _____

References

Name	Occupation	Address	Phone

Please provide three (3) volunteer or professional references that you have known for one or more years who are not related to you.

STATEMENT OF COMMITMENT

Please read and sign this section: If appointed as a member of the Planning Council, I commit to the following:

- I understand that I must complete a New Member Orientation within 3 months of beginning my term as a Planning Council member.
- I confirm that to the best of my ability, I will attend regularly scheduled monthly Planning Council meetings. I understand that in the event that I am unable to attend, I will notify Planning Council support in advance.
- I understand that membership on the Planning Council is a two year commitment. I have considered my other personal and professional obligations 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 understand that I must participate in at least one of the Standing Committees of the Planning Council.
- I understand that 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/AIDS 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 Planning Council
- I agree to keep sensitive information obtained about other Council members, including HIV status, confidential, unless otherwise given permission.
- I certify that all statements and representations made in this application are true and correct.

Signature _____ **Date** _____
(mm/dd/yr)

CONSENT

I hereby consent to have information about me as contained in this application become available to the entire Council and it's staff, and the TGA's grantee, the County of Middlesex and HRSA, the federal funding source of the Middlesex/Somerset/Hunterdon TGA as part of my work on the Council.

Signature _____ **Date** _____
(mm/dd/yr)

MIDDLESEX COUNTY OFFICE OF HUMAN SERVICES
APPLICATION FOR ADVISORY COUNCIL MEMBERSHIP

Name _____E-Mail_____

Home Address: _____

Home Phone_____ Cell Phone _____

Board Preference – Please indicate (✓) the group(s) to which you are applying:

____	Council for Children's Services	____	Homeless Trust Fund Task Force
____	Commission on Child Abuse & Missing Children	____	Local Advisory Council on Alcoholism and Drug Abuse - LACADA
____	Human Services Advisory Council (HSAC)	____	Mental Health Board
____	HIV Health Services Planning Council	____	Veterans' Advisory Council (please attach discharge papers)

Council Affiliation – Please check the group(s) you will represent on the council

____ Consumers ____ Advocates/professionals
____ Family Members ____ Specific Agency Representative
____ Other _____

Demographic – the following information is used solely to determine and ensure diversity in council appointments within the county

____ White ____ Asian, Indian or Pacific Islander ____ Senior (60+)
____ Black ____ American Indian, Eskimo or Aleut ____ Disabled
____ Hispanic ____ Female ____ Male ____ Veteran

Do you currently, or have you ever served on any other Middlesex County Council or Committee?
____ Yes ____ No If yes, please indicate which council and year(s) served

_____

Are you currently serving on a non-profit board that receives funding from Middlesex County?
____ Yes ____ No If yes, please indicate name of agency and type of funds

_____

Are you able to attend meetings scheduled during the day? ____ Yes ____ No
Are you able to attend meetings scheduled in the evening? ____ Yes ____ No
Will you need any special assistance to attend? _____

Please note the experiences you bring to the council that will help to support its functions/purpose

_____

_____

_____

Place of employment (if agency representative) _____
Job Title _____
Work Address_____
Work Phone_____

Do you prefer to be contacted at work, home or on cell phone? ____ Work ____ Home ____ Cell

- **Please attach a resume**

***** Alternate Format: This application is available in a large print edition. To request a copy, call 732-745-4186.***

Please return completed application to: *Melyssa Lewis, Director*
Middlesex County Office of Human Services
Middlesex County Administration Bldg. – 5th floor
75 Bayard Street
New Brunswick, NJ 08901

_____

FOR OHS OFFICE USE ONLY:

_____ Applicant being recommended for appointment to _____
(Indicate name of board)

In the following category:_____.

This recommendation has been approved by the board indicated above.

Notes:

_____ Office Director Approval

Updated: 1-Jun-16