

# Community Planning Group of Southern Nevada (CPG-SoN)

## Membership Application

### Mission Statement:

To prevent the spread of HIV infection in Southern Nevada through community participation in a prevention planning process leading to a comprehensive plan assuring effective prevention programs, education programs, and care activities that are responsive to community-identified needs within defined populations.

### General Information:

Name: \_\_\_\_\_

Organization (or Affiliation. Or Representation – such as Community Member) for purposes of this Planning Group: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ I prefer to be reached at: \_\_\_\_\_ (which phone)

### Applicant Questionnaire:

#### Membership Term

Membership in the Community Planning Group has been established as a minimum term of two years.

#### Time Commitment

Are you willing and able to commit to attending 6-8 meetings per calendar year and providing additional hours to participate on committees for this project over a period of two years? \_\_\_\_ Yes \_\_\_\_ No

#### Alternate Member Assignment

You have an opportunity to assign someone outside of the general membership as an “alternate” to attend a meeting and vote on issues on your behalf, for that meeting only. An alternate cannot attend and vote in your place at more than two consecutive meetings. The “alternate” assignment is meant to be used sparingly and allow the planning group to continue a smooth operation. If you have an alternate in mind at this time, please include their name below and fill out the attachment “Alternate Member PROXY Form” and return with your completed application for consideration.

Alternate Member: \_\_\_\_\_

#### Background

Please check any of the following services in which you have an educational background, professional affiliation or personal experience:

- |   |  |
|---|--|
| _____ Gay / Bi-Sexual Men’s HIV Prevention needs          | _____ Mental Health Services                 |
| _____ Women’s HIV Prevention / Care needs                 | _____ Other Non-Medical Support Services     |
| _____ Adolescent HIV Prevention / Care needs              | _____ Primary Care – Ambulatory / Outpatient |
| _____ General Public Health                               | _____ Primary Care – Drug Therapy            |
| _____ Substance Abuse / IDU – HIV Prevention / Care needs | _____ Evaluation                             |
| _____ Behavioral Sciences                                 | _____ Grant Writing Skills                   |
|   | _____ Other: _____                           |

## Demographics

The following information will help to ensure that Planning Group membership accurately reflects the current epidemic of HIV/AIDS in the Las Vegas Eligible Metropolitan Area. Please select the categories with which you most closely identify, even if you don't use the identical language (as provided below) to describe yourself. The information you provide will be combined with that of other Planning Group participants.

### I am:

- Male  
 Female  
 Transgender:  
      Male-Female  
      Female-Male

### Race:

- White  
 Black / African-American  
 Asian  
 Native Hawaiian / Pacific Islander  
 American Indian / Alaska Native  
 Refused To Answer  
 Don't Know

### HIV status:

- Positive     Don't Know  
 Negative     Refused To Answer

### Sexual Orientation:

- Gay (Male having sex with Males)  
 Lesbian (Female having sex with Females)  
 Bi-Sexual  
 Heterosexual  
 Other: \_\_\_\_\_  
 Refused To Answer

### Ethnicity:

- Hispanic / Latino  
 Not Hispanic or Latino  
 Refused To Answer  
 Don't Know

## Representation

Which of the following categories are you most qualified to represent? (Check as many as applicable and indicate which ones you consider more primary or secondary in your approach to this Planning Group.)

	<u>Primary</u>	<u>Secondary</u>
Healthcare provider ( <b>Not</b> Federally Qualified Health Center)	_____	_____
Healthcare provider (Federally Qualified Health Center)	_____	_____
CBOs serving affected population(s)	_____	_____
AIDS Services Organization	_____	_____
Social Service Provider	_____	_____
Mental Health Provider	_____	_____
Substance Abuse Provider	_____	_____
Local Public Health Agency	_____	_____
Hospital Planning Agency or Healthcare Planning Agency	_____	_____
Affected / Infected Communities	_____	_____
Self Representative	_____	_____
Non-Elected Community Leader	_____	_____
State Medicaid Agency	_____	_____
CARE Act – Title _____ (please specify)	_____	_____
Care Act – Part F (AETC – AIDS Education Training Center)	_____	_____
Housing Opportunity For Persons Living With AIDS	_____	_____
Educational Institution	_____	_____
Corrections / Probation	_____	_____
Representative From The Media	_____	_____

## Planning

Do you have any prior experience in HIV/AIDS Prevention/Care planning?  Yes  No

How much Prevention experience? \_\_\_\_\_

Please describe your experience: \_\_\_\_\_

Please indicate if you have any experience in the following areas:

- |  |  |
|--|--|
| <input type="checkbox"/> Communications/Interpersonal Skills | <input type="checkbox"/> Goals and Objectives        |
| <input type="checkbox"/> Conflict Resolution/Mediation       | <input type="checkbox"/> Budget Development          |
| <input type="checkbox"/> Small Group Facilitation            | <input type="checkbox"/> Conducting Needs Assessment |
| <input type="checkbox"/> Large Group Facilitation            | <input type="checkbox"/> Healthcare Research         |
| <input type="checkbox"/> Database Development                | <input type="checkbox"/> Statistical Analysis        |
| <input type="checkbox"/> Program Evaluation                  | <input type="checkbox"/> Other: _____                |

## Personal Experience

Do you know of a relative, partner or close friend who is living with HIV/AIDS or has died from HIV/AIDS?  Yes  No

## Committee Selection

The following are committees of the Planning Group. Please indicate **at least one** of which you would be interested in serving if you become a member of the Planning Group.

**Permanent SubCommittee:** If interested in this committee, please mark an "X" here: \_\_\_\_\_  
This committee meets more frequently than the general membership to address issues of State Plan development and documentation of CDC Community Planning Goals and Attributes. This working committee will present their work to the general membership for discussion, revisions and/or final approval.

For participation in any other committee, please mark an "X" by the committee listed below:

### **Standing Committees:**

- Nominations
- Evaluations
- Public Information

### **Ad-hoc Committees:**

- Bylaws
- Needs Assessment
- Resource Allocation

## Continuing Education

Are you willing to attend CEU programs?  Yes  No

## Languages Spoken

Do you speak any other languages fluently?:  Yes  No

Please list what languages: \_\_\_\_\_



Community Planning Group  
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**CPG-SoN Alternate Member PROXY Form**

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

**Member:** \_\_\_\_\_ hereby designates an Alternate Member as listed below:

Alternate Member PROXY -- Please fill out contact information below:

Name: \_\_\_\_\_ Title (optional): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number (work #): \_\_\_\_\_ (home #) \_\_\_\_\_

(cell #): \_\_\_\_\_ (fax #): \_\_\_\_\_

Best to reach me at (which phone number and best time of day): \_\_\_\_\_

Please send all correspondence via **e-mail** to: \_\_\_\_\_

(e-mail address)

Note: If fax or regular mail is preferred, please advise.

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General Background Information:

I first heard about the HIV Community Planning Group from: \_\_\_\_\_

My work/job role is: \_\_\_\_\_

I have received training or education in: \_\_\_\_\_

I am knowledgeable and/or have had experience (that would be an asset to this Planning Group): \_\_\_\_\_

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I have recently participated with the following groups within the last two years (please list HIV-related and non HIV-related groups):

Organization: \_\_\_\_\_ Role: \_\_\_\_\_

Organization: \_\_\_\_\_ Role: \_\_\_\_\_

**NOTE:**

If approved as an alternate, you will be allowed to attend meetings and have voting rights as a PROXY in place of regular member \_\_\_\_\_. You can always attend meetings as a guest when the regular member is in attendance but you will not have voting rights at those meetings.

If the regular member is not available to attend two consecutive meetings, the alternate will not be able to act as a PROXY in the second such meeting. The alternate can only attend the second such meeting as a guest.

I have read, understand and agree to the conditions noted above:

\_\_\_\_\_  
Alternate applicant

**Community Planning Group  
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**CPG-SoN Confidentiality Agreement**

This agreement by and between the Community Planning Group of Southern Nevada, hereinafter referred to as "CPG-SoN," and \_\_\_\_\_, hereinafter referred to as "Member," is made in view of the following circumstances:

- A. CPG-SoN and Member will enter into discussions regarding HIV infection, prevention, and education programs. During these discussions, highly sensitive and confidential information will be disclosed.
- B. Member recognizes the confidential nature of said CPG-SoN discussions. Member has agreed to sign this agreement in order to protect CPG-SoN from improper disclosure of confidential information.

The Member hereto agrees as follows:

- 1. All information provided by CPG-SoN to Member is confidential and is intended for the sole use of the CPG-SoN and/or Member in his/her evaluation regarding HIV infection, prevention, and education programs in confidence and to not directly, or indirectly reveal, report, publish, copy, disclose, or transfer any of the information to any other person or entity without prior written consent of the CPG-SoN, to wit:

**Member Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**County:** \_\_\_\_\_ **State:** \_\_\_\_\_

- 2. Should the Member hereto not comply with the CPG-SoN's Confidentiality Agreement, the Member will promptly return all documents, reports, etc. to the CPG-SoN and retain no copies.
- 3. This Confidentiality Agreement cannot be changed without prior written consent by the CPG-SoN.

Accepted and agreed to this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_

CPG Member (print your name): \_\_\_\_\_

CPG Member (signature on this line please): \_\_\_\_\_

**Community Planning Group of Southern Nevada:**

\_\_\_\_\_  
Marlo Tonge, Public Health Co-Chair

\_\_\_\_\_  
Kevin Moran, Community Co-Chair

**Community Planning Group  
of Southern Nevada (CPG-SoN)**



**CPG-SoN Conflict of Interest Disclosure**

The Community Planning Group of Southern Nevada (CPG-SoN) includes members who are professionally and/or personally affiliated with organizations that have, may request, or receive funds for HIV prevention activities for the Las Vegas Eligible Metropolitan Area (EMA.) Because of the potential for conflict of interest, all voting members of CPG-SoN must complete this disclosure.

By my signature below, I certify that:

1. I have read, understand, and support the section on Conflict of Interest, which is part of the CPG-SoN's Bylaws.
2. I and/or a family member am/is (have/has been within the last twelve months) serving/served in a staff, consultant, officer, board member, or advisory capacity with the following organization(s) that has/have received, or may seek, or is/are likely to be eligible for funding for HIV prevention activities from the Las Vegas EMA.

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**Organization** \_\_\_\_\_

**Role:** \_\_\_\_\_ **Period of Affiliation:** \_\_\_\_\_

**Organization** \_\_\_\_\_

**Role:** \_\_\_\_\_ **Period of Affiliation:** \_\_\_\_\_

**Organization** \_\_\_\_\_

**Role:** \_\_\_\_\_ **Period of Affiliation:** \_\_\_\_\_

**Organization** \_\_\_\_\_

**Role:** \_\_\_\_\_ **Period of Affiliation:** \_\_\_\_\_

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Date Signed: \_\_\_\_\_

CPG Member (print your name): \_\_\_\_\_

Member Signature: \_\_\_\_\_

**Community Planning Group of Southern Nevada:**

Date Received: \_\_\_\_\_ Reviewed By: \_\_\_\_\_

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