



**Recruitment and Retention into Care Training Participant Application**

Please complete the following information and return this form to:

National Minority AIDS Council  
Attention: Recruitment and Retention into Care Program  
1931 13<sup>th</sup> Street, NW  
Washington, DC 20009-4432

*All questions must be answered completely for consideration. Please print legibly or type. Email addresses are required.*

**Please check which training you are applying for**

\_\_\_\_\_ **Memphis, TN July 29<sup>th</sup> – 31<sup>st</sup>**  
**Deadline to apply July 6, 2009**

\_\_\_\_\_ **Los Angeles, CA August 19<sup>th</sup> - 21<sup>st</sup>**  
**Deadline to apply July 24, 2009**

**ORGANIZATIONAL INFORMATION**

**CONTACT INFORMATION FOR YOUR ORGANIZATION:**

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

Executive Director: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Website: \_\_\_\_\_



**1. Which of the following describes your organization (check all that applies)?**

- |                                                                            |                                                |
|----------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> AIDS Service Organization                         | <input type="checkbox"/> University or College |
| <input type="checkbox"/> Faith-based Organization                          | <input type="checkbox"/> Health Department     |
| <input type="checkbox"/> Substance Abuse Treatment Center                  | <input type="checkbox"/> PLWH/A Coalition      |
| <input type="checkbox"/> Publicly Funded Mental Health Center              | <input type="checkbox"/> Place of Worship      |
| <input type="checkbox"/> Hospital or Hospital-based Clinic                 | <input type="checkbox"/> Advocacy Organization |
| <input type="checkbox"/> Section 330 Community or<br>Migrant Health Center | <input type="checkbox"/> Other Non-profit      |

**2. What would you identify as your organizational challenges?**

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**3. What are your organizational challenges in addressing target groups?**

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**4. What current linkages or referrals has your agency implemented?**

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**5. Which of the following statements describes your organization (check all that apply)?**

- Organization has a physical location in a community whose residents are at risk for HIV infection, living with HIV/AIDS, or is predominantly racial/ethnic minorities
- Has historically served racial/ethnic minority patients or clients
- Over 50% of Board of Directors are racial/ethnic minorities



\_\_\_\_\_ Over 50% of key staff positions are held by racial/ethnic minorities (key staff positions include program supervisors, managers, and direct service providers)

\_\_\_\_\_ Organization has a physical location in or around a rural setting

\_\_\_\_\_ None of the above

**6. Does your organization currently provide direct services to people living with HIV/AIDS?**

\_\_\_\_\_ Yes

\_\_\_\_\_ No

**If so, what services does your organization provide?**

- |                                                         |                                |
|---------------------------------------------------------|--------------------------------|
| _____ HIV Counseling and Testing<br>Medical Care        | _____ Referrals for Specialty  |
| _____ Outpatient Mental Health Services                 | _____ Oral Health Care         |
| _____ Outreach Services for Entry into Care             | _____ Outpatient Medical Care  |
| _____ Outpatient Substance Abuse Treatment              | _____ Clinical Trial Referrals |
| _____ Nutritional Counseling Services                   | _____ AIDS Drug Assistance     |
| _____ Counseling, Education, Support on Living with HIV | _____ Case Management          |
| _____ Other (please specify): _____                     |                                |

**7. Please explain how your organization will expand or improve its core medical services and/or support services through participation in the Recruitment and Retention into Care training.**

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**8. How did you find out about the Regional training?**

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**Please identify the training participants in the next section**

**FIRST PARTICIPANT NAME:** \_\_\_\_\_

**Employment position:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone number (including extension):** \_\_\_\_\_

**SPECIAL NEEDS**

**Please indicate below any special accommodations you may need.**

Spanish language translation: \_\_\_\_\_

Meals: \_\_\_\_\_

Physical Accessibility: \_\_\_\_\_

Other: \_\_\_\_\_

**SECOND PARTICIPANT NAME:** \_\_\_\_\_

**Employment position:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone number (including extension):** \_\_\_\_\_

**SPECIAL NEEDS**

**Please indicate below any special accommodations that you may need.**

Spanish language translation: \_\_\_\_\_

Meals: \_\_\_\_\_

Physical Accessibility: \_\_\_\_\_

Other: \_\_\_\_\_



**TARGET POPULATION DESCRIPTION**

Please indicate below the categories that best describe your clients (check all that apply).

**GENDER**

- Male
- Female
- Transgender

**AGE**

- 24yrs or less
- 25-44 yrs
- 45-64 yrs
- 65 yrs or older

**SEXUALITY**

- Gay/Lesbian
- Bisexual
- MSM
- Heterosexual

**RACIAL/ETHNIC BACKGROUND**

- African American
- American Indian/Alaskan Native
- Asian
- Native Hawaiian/Pacific Islander
- Caucasian/White
- Hispanic or Latino/a
- More than one

**HIV STATUS**

- HIV+
- HIV-
- Unknown

**LOCATION**

- Rural
- Suburban
- Urban

*PLEASE NOTE: Completion of this registration application does not guarantee approval to participate. All applicants will be notified once a decision has been made regarding their application. Therefore, please do not make any plans to attend the conference until you have received approval from NMAC Recruitment and Retention staff.*

