

Leadership in Advocacy and Planning (LEAP) Training: Palm Springs, March 18-20, 2008



ELIGIBILITY REQUIREMENTS

Eligibility for participation in LEAP is limited to individuals living with HIV/AIDS who

- are interested in getting involved in Ryan White Program advisory and planning groups,
- are already involved, but feel a need for training/education on how these groups operate, or
- are interested in learning about HIV care planning and how to participate within their own communities.

THE LEAP TRAINING OFFERS INDIVIDUALS LIVING WITH HIV/AIDS...

- a safe space in which to explore individual leadership strengths and goals
- a better understanding of opportunities to participate in HIV planning and advocacy
- an increased sense of personal empowerment

Conceived, developed, and directed by people living with HIV and AIDS, the LEAP training is supported by the Health Resources and Services Administration (HRSA) through a cooperative agreement with the Academy for Educational Development (AED).

To obtain an application or to find out more information about the LEAP training, contact **Scott Thompson** at 202-884-8895 or sthompso@aed.org. Applications for the **Palm Springs, CA LEAP** training to be held at the Desert AIDS Project are **due by Sunday, March 2**. **Application to LEAP does not guarantee participation because space is limited.** You will be notified after we receive your application and it has been reviewed.

Please mail, fax, or email completed application forms to:

Scott Thompson
Academy for Educational Development
1825 Connecticut Avenue, NW
Washington, D.C. 20009
Fax: 202-884-8474
Email: sthompso@aed.org



Center on AIDS & Community Health

Leadership in Advocacy and Planning (LEAP) Training Application Form

(PLEASE PRINT ALL REQUESTED INFORMATION CLEARLY)

The following information is necessary for evaluating the program.

ALL INFORMATION SUBMITTED WILL BE KEPT COMPLETELY CONFIDENTIAL

****You must be HIV+ to be considered for this program****

Each LEAP training is two and a half days long. We ask that you commit to attending all three days. If you are selected to participate in LEAP, the Academy for Educational Development (AED) will contact you to provide the necessary logistical information.

Last Name: _____ First Name: _____ Middle Initial: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 County: _____ Phone: Day () _____ Evening () _____
 Fax: () _____ Email: _____

Mailing Address (*if different from above*)

Street Address _____
 City: _____ State: _____ Zip: _____

RACE/ETHNICITY

- American Indian
- Asian/Pacific Islander
- Latina/Latino
- Black, Non-Hispanic
 - African
 - Caribbean
- White/Non-Hispanic
- Other (please specify)

AGE GROUPING

- Adolescent (13-19)
- Young Adult (20-24)
- Adult (25-49)
- Adult (50 +)

EDUCATION

- High School: Grade ____
- High School Diploma/GED
- College – 2 Years
- College – 4 Years
- Graduate School
- Other (please specify)

EMPLOYED

- Yes No

SEX

- Male Female Transgender/Identify as Male Transgender/Identify as Female

SELF-IDENTIFICATION

Please check all of the categories that describe you:

- Individual with a history of substance abuse
- Individual who is in a drug treatment program
- Person living with HIV
- Person living with AIDS
- Individual with a history of incarceration
- Individual with a history of homelessness
- Individual with a history in the sex trade industry

- Bisexual Gay or Lesbian Heterosexual

How did you hear about LEAP?

- Friend Service Provider LEAP flyer Other (please specify) _____

Leadership in Advocacy and Planning (LEAP) Training Application Form

The Academy for Educational Development makes every effort to support your involvement in the LEAP training by providing the following:

- Local Transportation Reimbursement
- Meals during the training
- If needed , reimbursement for childcare provided by licensed providers

Please answer the following questions to help us support your involvement in LEAP:

1. Do you require any of the following to participate in LEAP?
(Please circle the appropriate response for each item below.)

Refrigeration for Medications **Yes** or **No**
Childcare Reimbursement **Yes** or **No**
Other **Yes** or **No**

2. Do you have any special dietary needs that we should be aware of? Please circle: **Yes** or **No**
If yes, please specify:

Vegetarian
 Other (please describe below)

3. Do you have any special physical needs that might affect your participation in LEAP?
Please circle: **Yes** or **No**
If yes, please specify:

Blind/Visually Impaired
 Deaf/Hard of Hearing
 Wheelchair user/Mobility Problems
 Other (please describe below)

Leadership in Advocacy and Planning (LEAP) Training Application Form

Please check all that apply from the following list. I am a...

- | | |
|---|---|
| <input type="radio"/> 1. Ryan White Part A (Title I) planning council member | <input type="radio"/> 7. Committee member of _____ |
| <input type="radio"/> 2. Ryan White Part B (Title II) consortium member | <input type="radio"/> 8. Community Advisory Board (CAB) |
| <input type="radio"/> 3. Part C (Title III) Advisory Group member | <input type="radio"/> 9. Member of PLWH Caucus/Group |
| <input type="radio"/> 4. Part D (Title IV) Advisory Group member | <input type="radio"/> 10. Staff or board member of a community based organization |
| <input type="radio"/> 5. ADAP Advisory Group member | |
| <input type="radio"/> 6. HIV prevention Community Planning Group (CPG) member | |

Please list and describe in your own words your community involvement in HIV/AIDS or Ryan White related activities, for example completion of leadership development or training programs offered by AIDS Alliance, NAPWA, Cicitelli Associates, etc.

What skills do you feel you would like to develop in order to be more effective in community work?

What do you expect to get out of the LEAP training?

How do you plan to use what you learn from the LEAP training?

Leadership in Advocacy and Planning (LEAP) Training Participant Information

The following information is necessary in case of an emergency. It is for our program use only.

Person to contact in case of emergency: _____

Phone: Day () _____ Evening () _____

Relationship: _____

Does this person know your HIV status? Yes ___ No ___

Do you have any medical condition *other than HIV/AIDS* that we should be aware of?
(Please circle) Yes or No

If yes, please describe below:
