Form Approved
OMB No. 0920-New
Expiration Date 00/00/000

Health Professional Application for Training (HPAT)- Paper

OMB Control No.
0920-xxxx
Exp. Date:

Health Professional Application for Training– ***Please print clearly***

Today's date_____
Course title_____ Course date_____

First name_____ Middle Initial_____ Last name_____
Degree_____ Title/Position_____
Organization_____
Address_____
City_____ State_____ Zip_____ Country (if not US)_____
Daytime Phone_____ Alt Phone _____ E-mail _____

Your Unique ID number is the first two letters of your first name, the first two letters of your last name, the month of your birth, and the day of your birth, plus the last four digits of your social security number. *For example*: John Smith, May 29 123-45-6789 would be **JOSM05296789**

FN	FN	LN	LN		M	M	D	D		#	#	#	#

UNIQUE IDENTIFIER

1. Your primary profession/discipline (*select ONE)*

☐ Dentist
☐ Other dental professional
☐ Advanced practice nurse
☐ Registered nurse
☐ Licensed practical nurse
☐ Pharmacist
☐ Physician
☐ Physician Assistant
☐ Clergy/Faith-Based Professional
☐ Dietitian/Nutritionist
☐ Health Educator
☐ Mental/behavioral health professional
☐ Social worker
☐ Substance abuse professional
☐ Community health worker
☐ Other (*please specify*)_____

2. Your primary functional role (*select ONE*)

☐ Administrator (director, coordinator, manager, supervisor)
☐ Agency Board member
☐ Clinician/Care provider
☐ Case manager
☐ Client/patient counselor
☐ Client/patient educator
☐ Clinical/medical assistant
☐ Disease intervention specialist / Partner services provider
☐ Intern /resident
☐ Mental/behavioral health therapist
☐ Outreach staff
☐ Peer support provider
☐ Researcher / evaluator
☐ Student/Graduate Student
☐ Teacher / faculty
☐ Trainer / TA Provider
☐ Other (*please specify)*_____

3. Your principal employment setting *(select ONE*):

☐ Academic Health Center
☐ College/University
☐ Community-based service organization (CBO)
☐ Community health center (e.g. Federally Qualified Health Center)
☐ Other non-profit health center
☐ Community/retail pharmacy
☐ Hospital/Hospital-affiliated clinic
☐ Military Health System/ Veterans Health Admin facility
☐ Private practice (Solo/group)
☐ Rural health center
☐ State/local health department
☐ Tribal/Indian Health Service facility

☐ Correctional facility
☐ HMO/managed care organization
☐ Non-Health Setting
☐ Other: *(please specify)*
☐Not working_(Go to question 11)_____

4. Primary programmatic focus of your work *(select up to TWO)*:

☐ HIV/AIDS
☐ STD
☐ TB
☐ Hepatitis
☐ Reproductive health / family planning
☐ Recovery support/ trauma/ domestic violence
☐ Labor and delivery
☐ Adolescent and/or pediatric health
☐ Emergency medicine / urgent care
☐ Primary care (e.g. genera/family medicine)
☐ Mental/behavioral health
☐ Oral health
☐ Other infectious diseases
☐ Other (*please specify*)_____

5. Primary Employment Setting

a. ☐ Rural ☐ Suburban/urban

b. Zip code

6. Is your employment setting a faith-based organization?

☐ Yes ☐ No ☐ Don't Know

7. Does your employment setting receive funding from any of these sources (select all that apply)?

a. Ryan White Program	☐ Yes	☐ No	☐ Don't know
b. Title X / Family Planning	☐ Yes	☐ No	☐ Don't know
c. CDC	☐ Yes	☐ No	☐ Don't know
d. SAMHSA	☐ Yes	☐ No	☐ Don't know
e. Minority AIDS Initiative	☐ Yes	☐ No	☐ Don't know

8. Please write the FULL name of your agency:

_____

Some programs and organizations provide services to a particular population group. In the following questions, please tell us about the population groups your program or organization serves.

9. Does your program predominantly serve any **racial and ethnic minority** groups?

☐ Yes (answer question 9a)
☐ No, my program does not focus on any specific racial and ethnic groups (Go to question 10)
☐ Don't know (Go to question 10)

9a. If yes, select up to TWO of the following **racial and ethnic** groups that are a focus of your program:

☐ American Indians or Alaska Natives
☐ Asians
☐ Blacks or African Americans
☐ Hispanics or Latinos/as
☐ Native Hawaiians or other Pacific Islanders
☐ Other (*please specify*) _____

10. Does your program predominantly serve any **special populations**?

☐ Yes (answer question 10a)
☐ No, my program does not focus on any specific population groups (Go to question 11)
☐ Don't know (Go to question 11)

10a. If yes, choose up to THREE of the following populations served by your program:

☐ Adolescents
☐ HIV+ individuals
☐ Homeless individuals
☐ Incarcerated individuals/parolees
☐ Low-income individuals
☐ Men who have sex with men
☐ Men who have sex with men and women
☐ Older adults
☐ Pregnant women
☐ Recent immigrants/refugees/migrants or seasonal workers
☐ Sex workers
☐ Substance users
☐ Transgender individuals
☐ Women
☐ Other *(please specify*) _____

12. What is your racial background? (Select all that apply?)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White

11. Are you of Hispanic, Latino/a, or Spanish origin?

☐ Yes ☐ No

13. What is your gender?

☐ Female ☐ Male ☐ Transgender: Female to male ☐ Transgender: Male to female

14. Do you provide services directly to clients or patients?

☐ Yes (Go to question 15)
☐ No (Stop here. You are done with this form.)

15. Please estimate the <u>PERCENTAGE</u> of your <u>OVERALL CLIENT/PATIENT</u> population in the past <u>YEAR</u> who were racial-ethnic minorities:

None/yr.	1-24%/yr.	25-49%/yr.	50-74%/yr.	≥75%/yr.
☐	☐	☐	☐	☐

15a. Please estimate the <u>PERCENTAGE</u> of your OVERALL CLIENT/PATIENT population in the past YEAR who received routine HIV testing:

None/yr.	1-24%/yr.	25-49%/yr.	50-74%/yr.	≥75%/yr.
☐	☐	☐	☐	☐

16. Do you provide services directly to <u>HIV-infected</u> clients/patients?

☐ Yes (Go to question 17)
☐ No (Stop here. You are done with this form.)

17. How many <u>YEARS</u> have you been providing services directly to HIV-infected clients/patients?

☐☐ (Round up to the nearest whole year)

18. Estimate the <u>NUMBER</u> of HIV-infected clients/patient to whom you provide direct services in an average <u>MONTH</u>.

None/mo.	1-9/mo.	10-19/mo.	20-49/mo.	50+/mo.
☐	☐	☐	☐	☐

For Questions 19 through 22, estimate the <u>PERCENTAGE</u> of your <u>HIV-infected</u> clients/patients in the past <u>YEAR</u> who are:

19. Racial-ethnic minorities

None/yr.	1-24%/yr.	25-49%/yr.	50-74%/yr.	≥75%/yr.
☐	☐	☐	☐	☐

20. Co-infected with Hepatitis C

None/yr.	1-24%/yr.	25-49%/yr.	50-74%/yr.	≥75%/yr.
☐	☐	☐	☐	☐

21. Receiving antiretroviral therapy

None/yr.	1-24%/yr.	25-49%/yr.	50-74%/yr.	≥75%/yr.
☐	☐	☐	☐	☐

22. Women

None/yr.	1-24%/yr.	25-49%/yr.	50-74%/yr.	≥75%/yr.
☐	☐	☐	☐	☐

Thank you for your valuable time.