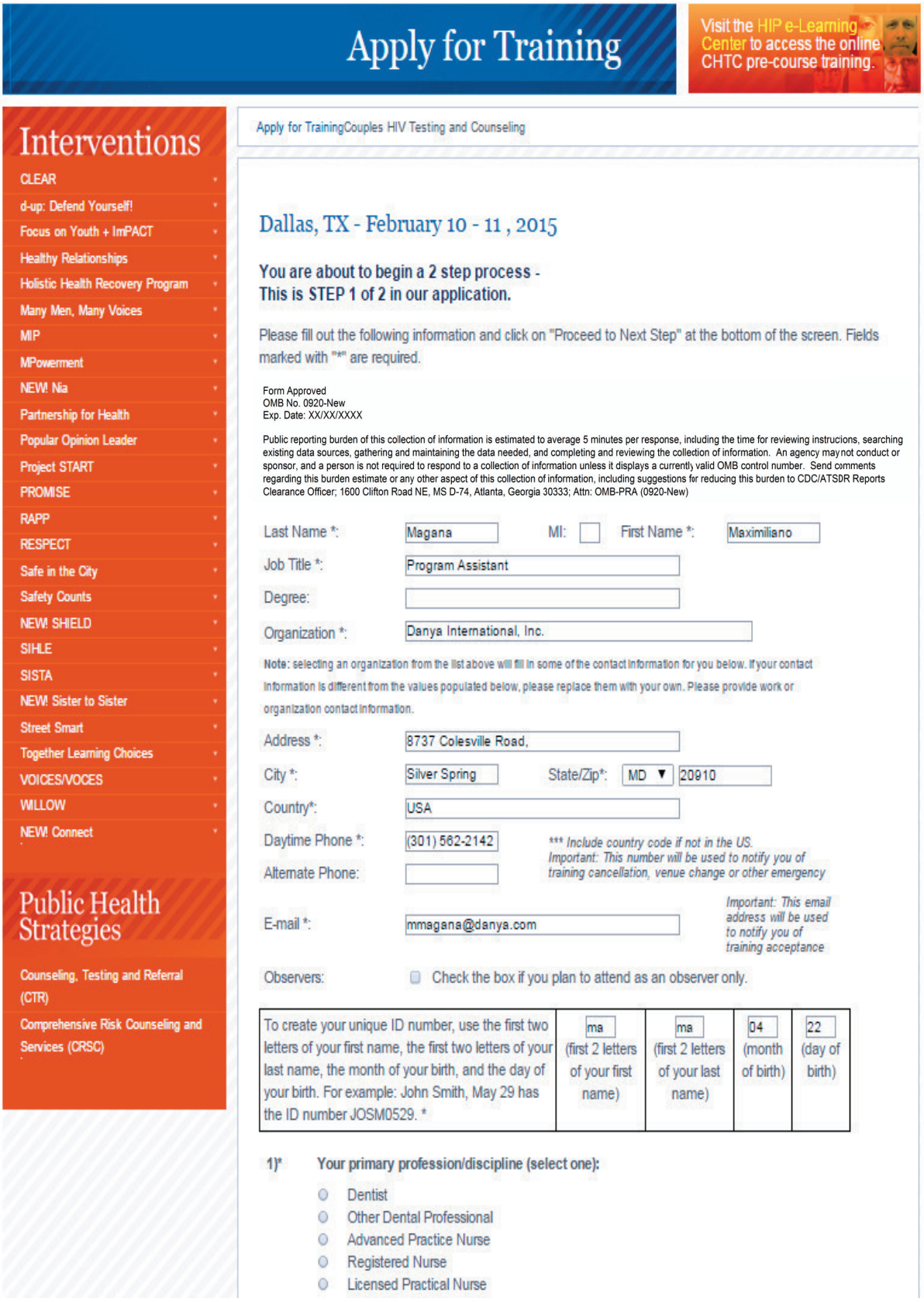
Attachment 4: Health Professional Application for Training (HPAT) - screenshots



Apply for Training

Visit the HIP e-Learning Center to access the online CHTC pre-course training.

Interventions

- CLEAR
- d-up: Defend Yourself!
- Focus on Youth + ImPACT
- Healthy Relationships
- Holistic Health Recovery Program
- Many Men, Many Voices
- MIP
- MPowerment
- NEW! Nia
- Partnership for Health
- Popular Opinion Leader
- Project START
- PROMISE
- RAPP
- RESPECT
- Safe in the City
- Safety Counts
- NEW! SHIELD
- SIHLE
- SISTA
- NEW! Sister to Sister
- Street Smart
- Together Learning Choices
- VOICES/VOCES
- WILLOW
- NEW! Connect

Public Health Strategies

- Counseling, Testing and Referral (CTR)
- Comprehensive Risk Counseling and Services (CRSC)

Apply for TrainingCouples HIV Testing and Counseling

Dallas, TX - February 10 - 11 , 2015

You are about to begin a 2 step process -
This is STEP 1 of 2 in our application.

Please fill out the following information and click on "Proceed to Next Step" at the bottom of the screen. Fields marked with "*" are required.

Form Approved
OMB No. 0920-New
Exp. Date: XX/XX/XXXX

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instrucions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

Last Name *: Magana MI: First Name *: Maximiliano

Job Title *: Program Assistant

Degree:

Organization *: Danya International, Inc.

Note: selecting an organization from the list above will fill in some of the contact information for you below. If your contact information is different from the values populated below, please replace them with your own. Please provide work or organization contact information.

Address *: 8737 Colesville Road,

City *: Silver Spring State/Zip*: MD 20910

Country*: USA

Daytime Phone *: (301) 562-2142 *** Include country code if not in the US. Important: This number will be used to notify you of training cancellation, venue change or other emergency

Alternate Phone:

E-mail *: mmagana@danya.com Important: This email address will be used to notify you of training acceptance

Observers: Check the box if you plan to attend as an observer only.

To create your unique ID number, use 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. For example: John Smith, May 29 has the ID number JOSM0529. *	ma (first 2 letters of your first name)	ma (first 2 letters of your last name)	04 (month of birth)	22 (day of birth)

1)* **Your primary profession/discipline (select one):**

- Dentist
- Other Dental Professional
- Advanced Practice Nurse
- Registered Nurse
- Licensed Practical Nurse

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 - testing

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 - tester

3)* **Your principal employment setting (select one):**

- ○ Academic Health Center
- ○ College/University
- ○ Community Based Organization (CBO)
- ○ Community Health Center (e.g. Federally Qualified Health Center)
- ○ Other Non-Profit Health Center
- ○ Community/Retail Pharmacy
- ○ Correctional Facility
- ○ HMO/Managed Care Organization
- ○ 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
- ○ Non-Health Setting
- ◉ Other - tester
- ○ Not Working (go to question 11)

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

- ☑ HIV/AIDS
- ☐ STD

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

- [x] HIV/AIDS
- [ ] STD
- [ ] TB
- [ ] Hepatitis
- [ ] Reproductive Health/Family Planning
- [ ] Recovery Support/Trauma/Domestic Violence
- [ ] Labor and Delivery
- [ ] Adolescent/Pediatric Health
- [ ] Emergency Medicine/Urgent Care
- [ ] Primary Care (e.g. General/Family Medicine)
- [ ] Mental/Behavioral Health
- [ ] Oral Health
- [ ] Other Infectious Diseases
- [ ] Other -

5)* **Primary Employment Setting (physical location of your primary office):**

a. ○ Rural ◉ Suburban/Urban

b. Zip Code: 20910

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)?**

Ryan White Program	○ Yes	○ No	◉ Don't Know
Title X/Family Planning	○ Yes	○ No	◉ Don't Know
CDC	○ Yes	○ No	◉ Don't Know
SAMHSA	○ Yes	○ No	◉ Don't Know
Minority AIDS Initiative	○ Yes	○ No	◉ Don't Know

8)* **Please write the FULL name of your agency:**

danya int. testing

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/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
- [ ] Hispanics/Latinos/as
- [ ] Asians
- [ ] Native Hawaiian/Pacific Islanders
- [ ] Blacks/African Americans

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) -

11)* **What is your racial background? (select all that apply)**

- [x] American Indian or Alaska Native
- [ ] Asian

11)* **What is your racial background? (select all that apply)**

- [x] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [x] White

12)* **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 (go to question 23)

15a) **Please estimate the *PERCENTAGE* of your *OVERALL CLIENT/PATIENT* population in the past *YEAR* who were racial-ethnic minorities:**

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

15b) **Please estimate the *PERCENTAGE* 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 *HIV-infected* clients/patients?**

○ Yes (go to question 17) ○ No (go to question 23)

17) **How many *YEARS* have you been providing services directly to HIV-infected clients/patients?**

[ ] (Round up to the nearest whole year)

18) **Estimate the *NUMBER* of HIV-infected clients/patients to whom you provide direct services in an average *MONTH*.**

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

*For Questions 19 through 22, estimate the **PERCENTAGE** of your **HIV-infected** clients/patients in the past **YEAR** 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 Anti-retroviral 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.