


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

## Apply for 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

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## 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 instructions, 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 \*:  MI:  First Name \*:

Job Title \*:

Degree:

Organization \*:

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 \*:   
 City \*:  State/Zip\*:    
 Country\*:   
 Daytime Phone \*:  *\*\*\* 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 \*:  *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. *	<input type="text" value="ma"/> <small>(first 2 letters of your first name)</small>	<input type="text" value="ma"/> <small>(first 2 letters of your last name)</small>	<input type="text" value="04"/> <small>(month of birth)</small>	<input type="text" value="22"/> <small>(day of birth)</small>
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**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 -

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 -

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 -
- 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):**
- |  |  |
|--|--|
| <input checked="" type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> STD   |
| <input type="checkbox"/> TB                                  | <input type="checkbox"/> Hepatitis                                   |
| <input type="checkbox"/> Reproductive Health/Family Planning | <input type="checkbox"/> Recovery Support/Trauma/Domestic Violence   |
| <input type="checkbox"/> Labor and Delivery                  | <input type="checkbox"/> Adolescent/Pediatric Health                 |
| <input type="checkbox"/> Emergency Medicine/Urgent Care      | <input type="checkbox"/> Primary Care (e.g. General/Family Medicine) |
| <input type="checkbox"/> Mental/Behavioral Health            | <input type="checkbox"/> Oral Health                                 |
| <input type="checkbox"/> Other Infectious Diseases           | <input type="checkbox"/> Other - <input type="text"/>                |
- 5)\* **Primary Employment Setting (physical location of your primary office):**
- 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)?**
- |                          |                           |                          |   |
|--------------------------|---------------------------|--------------------------|---|
| Ryan White Program       | <input type="radio"/> Yes | <input type="radio"/> No | <input checked="" type="radio"/> Don't Know |
| Title X/Family Planning  | <input type="radio"/> Yes | <input type="radio"/> No | <input checked="" type="radio"/> Don't Know |
| CDC                      | <input type="radio"/> Yes | <input type="radio"/> No | <input checked="" type="radio"/> Don't Know |
| SAMHSA                   | <input type="radio"/> Yes | <input type="radio"/> No | <input checked="" type="radio"/> Don't Know |
| Minority AIDS Initiative | <input type="radio"/> Yes | <input type="radio"/> No | <input checked="" type="radio"/> 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/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:**
- |   |  |
|---|--|
| <input type="checkbox"/> American Indians or Alaska Natives | <input type="checkbox"/> Hispanics/Latinos/as              |
| <input type="checkbox"/> Asians                             | <input type="checkbox"/> Native Hawaiian/Pacific Islanders |
| <input type="checkbox"/> 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:**
- |  |  |
|--|--|
| <input type="checkbox"/> Adolescents                                   | <input type="checkbox"/> HIV+ Individuals  |
| <input type="checkbox"/> Homeless Individuals                          | <input type="checkbox"/> Incarcerated Individuals/Parolees                       |
| <input type="checkbox"/> Low Income Individuals                        | <input type="checkbox"/> Men Who Have Sex With Men                               |
| <input type="checkbox"/> Men Who Have Sex with Men and Women           | <input type="checkbox"/> Older Adults  |
| <input type="checkbox"/> Pregnant Women                                | <input type="checkbox"/> Recent Immigrants/Refugees/Migrants or Seasonal Workers |
| <input type="checkbox"/> Sex Workers                                   | <input type="checkbox"/> Substance Users   |
| <input type="checkbox"/> Transgender Individuals                       | <input type="checkbox"/> Women   |
| <input type="checkbox"/> Other (please specify) - <input type="text"/> |  |
- 11)\* **What is your racial background? (select all that apply)**
- |  |                                |
|--|--------------------------------|
| <input checked="" type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian |
|--|--------------------------------|

- 11)\* 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

- 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.