

University of South Carolina
Arnold School of Public Health
Informed Consent Form

Disclosure

The Institute for HIV Prevention Leadership is being sponsored by the Centers for Disease Control and Prevention. The goal of the Institute is to enhance the HIV prevention capacity of state and local health departments through the provision of public health prevention and strategic management training to HIV prevention program managers and other personnel and organizations with whom they work in planning, implementing, and evaluating HIV prevention programs. The evaluation of the Institute is being conducted by the University of South Carolina, Arnold School of Public Health.

If you apply to participate in the Institute, you must fill out the attached questionnaire on your background, knowledge of public health prevention and strategic management, and organizational learning. In addition, it is expected that you will complete other questionnaires related to the Institute that are sent to you. The questionnaire will be detached from your application to participate in the Institute for HIV Prevention Leadership and will be kept in a separate file. This informed consent form will be detached from the questionnaire upon receipt of your application packet in order to maintain confidentiality. The Institute staff will not identify you or your organization in any publications and all records will be kept strictly confidential. The information will be documented in a way that neither you nor your organization can be identified and only Institute staff will have access to the identifying information.

Consent

I understand that by applying to participate in the Institute for HIV Prevention Leadership I am also agreeing to participate fully in its evaluation. I understand that the evaluation will include the completion of multiple survey instruments and informal interviews with Institute staff. I also understand that, though complete, honest, and accurate information is important, I may refuse to answer some questions and may withdraw my consent at any time without prejudice.

I understand that there is no risk to my organization or to me if I participate. I may benefit from participation in this evaluation in that this and subsequent offerings of the Institute for HIV Prevention Leadership may be tailored to meet the needs and knowledge of participants. As a result, the HIV prevention capacity of community-based organizations may be enhanced. In addition, the populations-at-risk and those already infected with HIV may benefit from these improved HIV prevention services.

I understand that I may ask questions at any time and that if I have additional questions I may contact: Dr. Donna L. Richter, University of South Carolina, the Arnold School of Public Health, Columbia, SC 29208. Phone: (803) 734-1590. I also affirm that I have been given a copy of the informed consent form.

Signature: _____ Date: _____

Application Form

Please read all instructions before completing this form. Type or print clearly in black or blue ink, answer ALL questions, using “None” or “N/A” if appropriate.

Personal Information

Name: _____
First Middle Last

Home Address: _____
Street

City State Zip

Home Telephone: () _____

Personal Email Address: _____

Business Information

CBO: _____

Your Job Title: _____

Mailing Address: _____
Street

City State Zip

Business Phone: _____ Business Fax: _____

Your Business Email: _____

Supervisor's Name: _____ Supervisor's Title: _____

Executive Director's Name: _____

I am applying under:

- Category A: (Directly CDC funded)** Check the box beside the Program Announcement Number under which your CBO receives funding (check all that apply).
- CDC Program Announcement 08803
 - CDC Program Announcement 04019
 - CDC Program Announcement 04064
 - CDC Program Announcement 05051
 - CDC Program Announcement 06618

- Category B: (not directly CDC funded)***
Specify the name of the Health Department under which you are funded:

**Please remember to include the Supplemental Eligibility Form along with your application.*

If you are not directly or indirectly funded by the CDC, please indicate your CBO's funding source* below:

- Private funding (i.e., foundation or private company)
- No funding source

**If your CBO is not funded according to Category A or B above, then you do not meet our eligibility criteria (see pages 2-3).*

Emergency Contact

Name: _____

Relationship: _____ Phone: _____

Please check yes or no:

My CBO is minority-based. [To be considered as a minority-based CBO, your organization must serve minority populations as defined by the program announcement or contract under which the agency was funded and have provided HIV prevention services in each of the last three years to minority populations.]

- Yes No

The above information is correct to the best of my knowledge. By signing below, I agree to all terms and conditions as stipulated in this application packet and will agree to adhere to Institute policies. In the event that I am unable to complete the CDC/ASPH Institute for HIV Prevention Leadership, I will return the laptop computer to the Institute in working order.


Signature: _____ Date: _____

The CDC/ASPH Institute for HIV Prevention Leadership has a non-discrimination policy and does not discriminate against any individual on the basis of personal characteristics such as race, color, religion, gender, national origin, age, disability, sexual orientation, or veteran status.



Essay Question 1

Using this form, please write an essay, no longer than 2 typed pages (12 point font, double-spaced), which briefly describes one of the most challenging issues your CBO faces in HIV prevention and how participation in the CDC/ASPH Institute for HIV Prevention Leadership may help you address this issue.




Essay 1 – Continued:



Essay Question 2

Using this form, please write an essay, no longer than 2 typed pages (12 point font, double-spaced), which briefly describes your leadership style and how participation in the Institute is relevant to your professional development goals.



Essay 2 – Continued:

CDC/ASPH Institute for HIV Prevention Leadership Letter of Support from CBO

This form is to be completed by an **authorized representative** of the applicant's CBO, preferably the Executive Director or the President of the Board of Directors of the CBO.

Name of Applicant: _____

This applicant to the CDC/ASPH Institute for HIV Prevention Leadership has the full support of his/her CBO during his/her participation in this program. If this applicant is accepted as a scholar in the program, his/her CBO agrees to:

- Pay the Scholar's salary while he/she attends the Institute for HIV Prevention Leadership.
- Maintain and insure the laptop computer the scholar receives. This laptop is not to be upgraded or changed in any way during the Institute program year.
- Participate in the Integrative Learning Experience exercises, where appropriate.
- Reimburse the Institute for any unauthorized changes or cancellations to travel arrangements to the four on-site sessions of the Academy.

It is also understood that:

- The laptop computer will become the property of this CBO upon the scholar's successful completion of the Institute. Should the scholar not complete the Institute, the laptop computer will be returned in good working order to the Institute immediately.
- Use of the laptop computer will be restricted to the scholar only during the Institute year.
- The Scholar's supervisor will be informed of the Scholar's performance during the Institute program year.
- Approximately 20 hours of time between each Institute week will be needed to complete the Integrative Learning Experience assignments in addition to the 4 weeks of classroom time.

As an **authorized representative** of the applicant's CBO, I fully understand and agree to the above. This applicant has the support of this CBO to participate in the CDC/ASPH Institute for HIV Prevention Leadership.

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Phone: _____ Email: _____

CDC/ASPH Institute for HIV Prevention Leadership Letter of Support from Supervisor

This form is to be completed by the applicant's *immediate supervisor*. If the applicant's immediate supervisor is the Executive Director or President of the Board of Directors, and has signed the Letter of Support from CBO, then it is not necessary to complete this form.

Name of Applicant: _____

This applicant to the CDC/ASPH Institute for HIV Prevention Leadership has the full support of his/her Supervisor during his/her participation in this program. If this applicant is accepted as a scholar in the program, his/her Supervisor agrees to:

- Allow the Scholar to attend the Institute for HIV Prevention Leadership.
- Participate in the Integrative Learning Experience exercises, where appropriate.

It is also understood that:

- The laptop computer will become the property of this CBO upon the scholar's successful completion of the Institute. Should the scholar not complete the Institute, the laptop computer will be returned in good working order to the Institute immediately.
- Use of the laptop computer will be restricted to the scholar only during the Institute year.
- The Scholar's supervisor will be informed of the Scholar's performance during the Institute program year.
- Approximately 20 hours of time between each Institute week will be needed to complete the Integrative Learning Experience assignments in addition to the 4 weeks of classroom time.

As the applicant's **supervisor**, I fully understand and agree to the above. This applicant has my support to participate in the CDC/ASPH Institute for HIV Prevention Leadership.

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Phone: _____ Email: _____

**Institute for HIV Prevention Leadership
Letter of Recommendation Form**

Section 1) To be completed by the applicant.

Name of Applicant: _____

Waiver of Access:

I, the undersigned, waive the right of personal access to the reference. (If signed, this document becomes confidential.)

Signature: _____ Date: _____

Section 2) To be completed by the person making the recommendation.

You have been asked to recommend this person for admission to the Institute for HIV Prevention Leadership. We would greatly appreciate your completing this form at your earliest convenience and returning it to the address listed below. Please submit this form in a sealed envelope, with your signature across the seal. If you wish, you may supplement this form with a written letter.

Upon request, the applicant may view this form unless the above waiver has been signed.

Please send the completed form to:

**Institute for HIV Prevention Leadership
2221 Devine Street, Room 219
Columbia, SC 29205
Attn: Rachel Guza**

Name of Recommender: _____

Organization: _____

Phone: _____ Email: _____

1. In what capacity do you know the applicant, and how well do you know the applicant?

2. How long have you known the applicant?

3. Give your opinion of the applicant's qualification in the following areas to work in HIV prevention programs.

	Highly Qualified	Qualified	Marginally Qualified	Unqualified
Oral communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Written communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work in teams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General knowledge of HIV prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Willingness to learn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please provide any comments about the applicant that may be useful in evaluating his/her application.

Signature: _____ Date: _____

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Computer skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work in teams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General knowledge of HIV prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Willingness to learn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Computer skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work in teams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General knowledge of HIV prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Willingness to learn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please provide any comments about the applicant that may be useful in evaluating his/her application.

Signature: _____ **Date:** _____

Institute for HIV Prevention Leadership Supplemental Eligibility Form

This form is for applicants from CBOs funded by a state, city, or local health department via a CDC cooperative agreement, and not funded directly by CDC. This form should be completed by an authorized official in the state, city, or local health department from which the CBO receives funding.

Please send the completed form to:

Institute for HIV Prevention Leadership
2221 Devine Street, Room 219
Columbia, SC 29205
Attn: Rachel Guza

The purpose of this form is to verify the funding source of the applicant's CBO, the stability of the CBO, and that the CBO is minority-based. To be considered as a minority-based CBO, the organization must serve minority populations as defined by the program announcement or contract under which the agency was funded and have provided HIV prevention services in each of the last three years to minority populations.

Section 1) Applicant Information

To be completed by the applicant (please type or print).

Name of Applicant: _____
First Middle Last

Name of CBO: _____

Section 2) Funding Source Information

To be completed by an authorized official of the funding source (please type or print).

Name of Health Department: _____

Mailing Address: _____

City, State, Zip: _____

Name of Authorized Official Completing this form: _____

Title of Authorized Official: _____

Telephone: _____

Fax: _____

Section 3) Verification of Eligibility

To be completed by an authorized official of the funding source (please type or print).

1. Is the applying CBO **currently** funded by your agency?

Yes _____ No _____ I Don't Know _____

2. Has the applying CBO received financial support directly from your agency for **at least one year**?

Yes _____ No _____ I Don't Know _____

3. Has the applying CBO received financial support directly from your agency through a CDC cooperative agreement for at least one year?

Yes _____ No _____ (go to #4) I Don't Know _____ (go to #4)

a. If yes, please indicate below the most current year that the applying CBO has received this type of funding, the amount of the award, and the duration of the award (number of years the funding covers):

Year _____ Amount _____ Duration (number of years) _____

4. Does the applying CBO currently provide HIV prevention programs to minority and/or underserved populations?

Yes _____ No _____ I Don't Know _____

5. Is the applying CBO currently a minority-based CBO?

Yes _____ No _____ I Don't Know _____

6. Do you have good reason to believe that the applying CBO is stable and will continue to provide HIV prevention programs for the **next five years**?

Yes _____ No _____ I Don't Know _____

Section 4) Signature

Signature: _____ **Date:** _____