



**AIDS Consumer Empowerment Series
Application**



Please print legibly in blue ink. Please read through the entire application before you start filling it out, so that you are sure you understand what you will need to do. You must be over 18 years of age and be living with HIV/AIDS to participate in this program.

SECTION 1: APPLICANT INFORMATION

Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Daytime Phone Number _____ Other Number _____

Age: 18-24 25-39 40-50 51+

Gender: _____

Sexual Orientation (optional):

Heterosexual Gay Lesbian Bisexual Other _____

Ethnicity/Race (optional):

African American/Black Native American
 Hispanic/Latino (a) Asian American/Pacific Islander
 White (non-Hispanic) Other (please specify) _____

What is your primary language?

English Spanish Other (please specify) _____

Are you openly living with HIV/AIDS? Yes No

Do you work or volunteer in the AIDS field? Yes No

If so, for how long? _____

What is the highest level of education you have completed (please circle one):

8 9 10 11 12 GED Some College Grad College Other _____

Were you referred by a former ACES graduate? If so, who? _____

Case Manager's Name _____ Agency _____
Phone Number _____

SECTION 2: PROGRAM INFORMATION

Do you have regular access to the following? (Please check all that apply)

- Fax Machine Computer Email

If you have access to a fax machine, what is the number? _____

If you have access to email, what is your email address? _____

Do you regularly use email to communicate? Yes No

If so, how often do you check email? Daily 2-3 times per week Once per week

Why are you applying to the ACES program?

What are your expectations of the ACES Program?

SECTION 3: LEADERSHIP & COMMUNITY SERVICE

Have you participated as any of the following in your local community in the past five years? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Planning Council Member | <input type="checkbox"/> HIV/AIDS Educator |
| <input type="checkbox"/> Community Planning Group (CPG) | <input type="checkbox"/> Community Advocate |
| <input type="checkbox"/> Support Group Facilitator | <input type="checkbox"/> Community Advisory Board |
| <input type="checkbox"/> Volunteer | <input type="checkbox"/> Other _____ |

Have you done either of the following? (Please check all that apply)

- Public Speaking Presented a workshop or other training

If you have presented a workshop or done any public speaking, please describe what you did and what your role and responsibilities were (attach additional sheets if necessary).

SECTION 4: TURNING IN YOUR APPLICATION

APPLICATION CHECK LIST:

- Completed application
- Two letters of recommendation

You can send your completed application to CARC (Connecticut AIDS Resource Coalition) by e-mail, mail or fax.

To mail your application, please send them to the following address:

**CARC
ACES Program
110 Bartholomew Ave, Suite 4000
Hartford, CT 06106**

To fax your application, please send them to the attention of **Consumer Empowerment Coordinator**, fax number (860) 761-6711.

To email your application, please send them to andre@ctaidcoalition.org.

If you have questions please call André Cabán at (860) 761-6699 x 305, or via email at the address provided above.

Name (PRINT) _____

Signature _____

Date _____