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CAEAR - Cities Advocating Emergency AIDS Relief [1]

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S	67	1	1	3

THE Sheridan GROUP

LOBBYING YOUR MEMBER OF CONGRESS

Lawmakers need first-hand input from voters as well as community leaders to make sound decisions. As few as 30 letters from constituents in a congressional district or state can affect the votes of undecided legislators. When professional lobbyists argue against your interests, lawmakers can respond, "That's not what I hear from the people in my district." You, as an advocate, or constituent, can be the most effective lobbyist!

Whether you are writing letters, phoning, or meeting with legislators, you should:

DO YOUR HOMEWORK - Review all pertinent information; review your Representative's and/or Senator's stated positions and voting records; know what committees they serve on; decide when your contact will have the greatest effect (usually just before a piece of legislation is to come before a committee or when a bill will soon come before either the full House or Senate).

IDENTIFY YOURSELF - Introduce yourself as a voter from a specified city/county, congressional district, or state. Identify any other personal or professional relationships that will lend weight and credibility to your position on the issue (e.g. "I am a member of X organization or Association").

BE SPECIFIC - Clearly state the bill in which you are interested. Indicate precisely what action you want the legislator to take (i.e. vote for, send letter of support to appropriators, etc).

BE CONCISE - Stick to the facts of the issue at hand.

BE EVEN-HANDED - Take the time to contact your Members of Congress when you approve of their actions, as well as when you wish to voice opposition or ask for consideration. Always write to thank a Senator or Representative for positive action taken on a previous request.

ASK FOR A COMMITMENT - Without making threats or promises, try to get the legislators commitment to vote for or against a bill, to cosponsor legislation, or to take a leadership role on an issue. Ask for the legislator's position, but do not expect an immediate commitment.

BE PERSISTENT - Keep the pressure on. Don't stop after just one contact. Follow-up one kind of contact with another. There is power in numbers. You might organize a constituent letter-writing, call-in, or postcard campaign to encourage a reluctant legislator to support your point of view.

REMEMBER THE FOUR P'S:
BE PROMPT, PATIENT, POLITICAL, AND PERSISTENT!

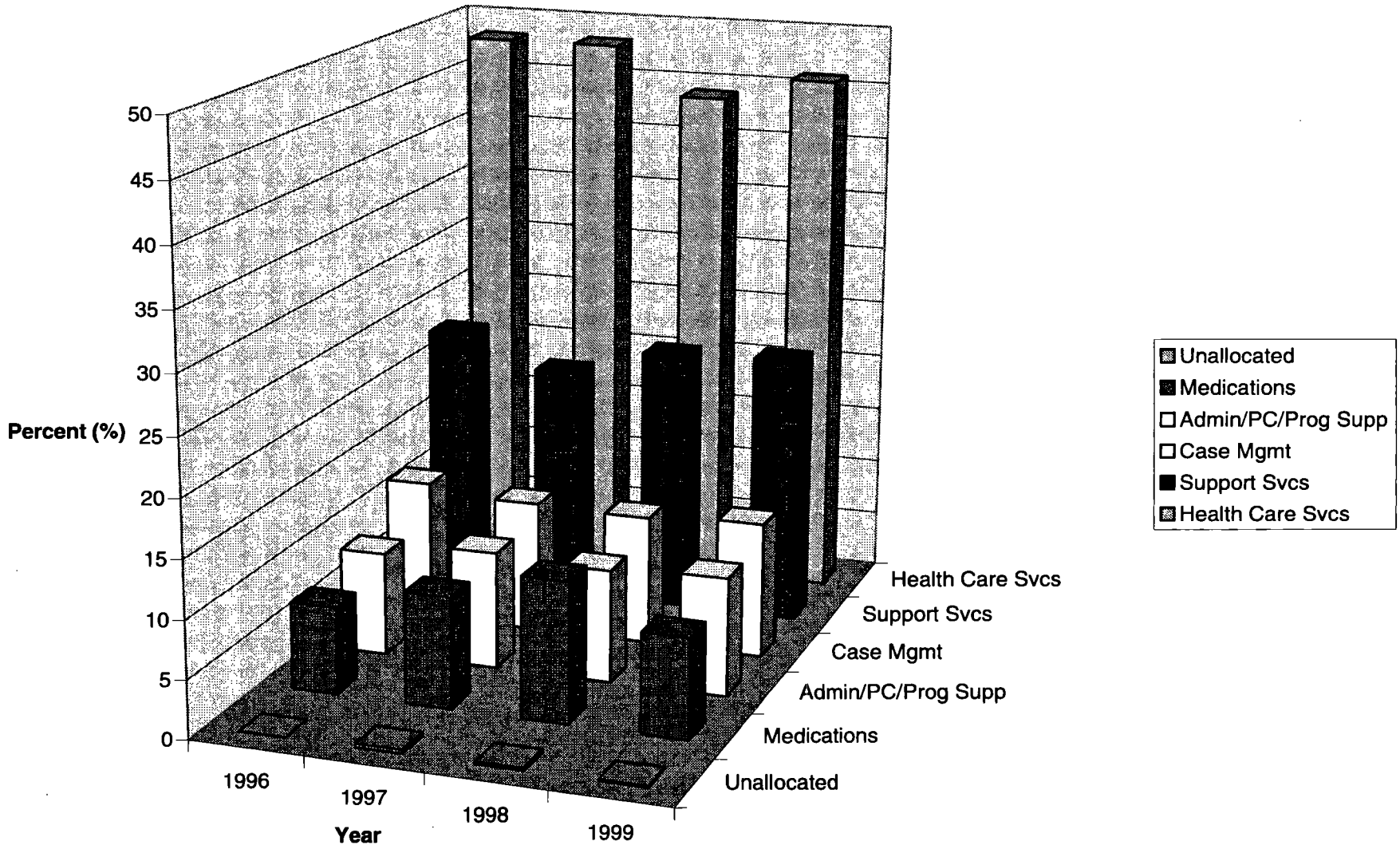
The Sheridan Group, 1808 Swann Street, NW Washington, DC 20007
phone: 202-462-7288 fax: 202-483-1964 website www sheridangroupdc.com

Ryan White Care Act Awards FY 99 vs. FY 00 (includes formula, supplemental and minority initiative funding)

EMA	FY 99 TOTAL	FY 00 TOTAL	Difference	Percent Change
Atlanta	13,147,268	15,507,832	2,360,564	18%
Austin	3,175,509	3,575,995	400,486	13%
Baltimore	13,478,549	15,351,112	1,872,563	14%
Bergen	4,320,176	4,626,995	306,819	7%
Boston	10,647,381	12,469,255	1,821,874	17%
Caguas	1,610,314	1,713,686	103,372	6%
Chicago	18,227,884	19,003,954	776,070	4%
Cleveland	2,933,058	3,107,796	174,738	6%
Dallas	10,164,078	11,077,000	912,922	9%
Denver	4,150,341	4,581,734	431,393	10%
Detroit	6,585,744	7,234,813	649,069	10%
Dutchess	1,220,662	1,208,858	-11,804	-1%
Ft Lauderdale	10,810,324	11,437,539	627,215	6%
Ft Worth	2,935,543	2,968,606	33,063	1%
Hartford	4,019,409	4,417,574	398,165	10%
Houston	15,489,996	17,665,434	2,175,438	14%
Jacksonville	3,683,146	4,175,873	492,727	13%
Jersey City	5,015,785	5,541,714	525,929	10%
Kansas City	2,952,910	3,064,120	111,210	4%
Las Vegas	1,800,211	3,689,337	1,889,126	105%
Los Angeles	33,540,737	34,683,327	1,142,590	3%
Miami	21,248,387	23,450,383	2,201,996	10%
Middlesex	2,555,029	2,750,975	195,946	8%
Minneapolis	2,548,603	2,826,949	278,346	11%
Nassua	5,632,012	6,118,736	486,724	9%
New Haven	6,100,471	6,261,941	161,470	3%
New Orleans	5,695,360	5,935,834	240,474	4%
New York	96,961,856	107,560,148	10,598,292	11%
Newark	14,390,269	14,554,092	163,823	1%
Norfolk	1,948,137	4,089,698	2,141,561	110%
Oakland	6,218,532	6,704,657	486,125	8%
Orange	4,300,690	4,670,880	370,190	9%
Orlando	4,907,180	6,007,600	1,100,420	22%
Philadelphia	16,011,451	18,134,011	2,122,560	13%
Phoenix	3,865,319	5,001,568	1,136,249	29%
Ponce	2,487,768	2,460,695	-27,073	-1%
Portland	3,115,251	3,216,312	101,061	3%
Riverside	6,463,388	6,913,948	450,560	7%
Sacramento	2,578,873	2,744,171	165,298	6%
St Louis	3,664,771	4,239,080	574,309	16%
San Antonio	3,014,654	3,163,374	148,720	0%
San Diego	8,872,685	9,071,625	198,940	2%
San Francisco	36,218,513	35,246,477	-972,036	-3%
San Jose	2,486,136	2,612,060	125,924	5%
San Juan	11,912,865	13,558,330	1,645,465	14%
Santa Rosa	1,127,018	1,152,406	25,388	2%
Seattle	5,303,343	5,488,688	185,345	3%
Tampa	7,236,728	8,016,131	779,403	11%
Vineland	688,648	684,897	-3,751	-1%
Washington	18,322,558	19,903,750	1,581,192	9%
W. Palm Beach*	6,711,944	7,169,030	457,086	7%
	482,497,464	526,811,000	44,313,536	9%

* FY 00 figure inferred from data; actual award was missing from table supplied by HHS

Title I Budget Allocation Trends by Service Category



Resource Allocation in a National HIV Care Program
49 (51 as of 1999) Metropolitan Areas of the United States by Service Category
1996-1999 Dollar Amounts

Service Category	*1996*	*1997*	*1998*	*1999*
Health Care Services Subtotal:	**$181,365,527**	**$206,959,230**	**$203,938,011**	**$221,694,926**
Medical Care	$91,616,182	$106,811,410	$107,370,541	$119,319,687
Dental Care	$10,722,035	$12,094,813	$12,975,107	$14,110,968
Mental Health	$25,901,340	$26,137,997	$24,884,209	$28,513,146
Substance Abuse	$27,101,669	$27,519,914	$30,953,549	$36,456,647
Home Health Care	$18,573,057	$16,168,635	$10,325,563	$11,334,709
Health Insurance Cont.	$1,276,161	$1,293,570	$2,373,456	$1,725,396
Hospice	$3,227,104	$4,406,081	$5,507,895	$3,342,916
Rehabilitation	$1,065,242	$729,783	$67,959	$69,021
Inpatient Personnel	$137,519	$368,081	$624,814	$0
Other Local Health Care	$1,745,218	$11,428,946	$8,854,918	$6,822,436
Medications:	**$28,178,678**	**$41,051,269**	**$55,920,701**	**$41,540,790**
Case Management:	**$45,783,708**	**$48,818,440**	**$51,672,126**	**$56,627,545**
Support Services Subtotal:	**$87,351,492**	**$87,977,744**	**$105,811,935**	**$112,333,721**
Nutrition/Food	$16,285,600	$19,039,940	$24,712,151	$24,755,614
Transportation	$8,079,014	$9,032,725	$10,603,120	$10,992,238
Housing	$22,082,673	$23,764,978	$22,451,870	$23,414,839
Emergency Assistance	$5,124,300	$6,604,307	$10,134,458	$9,980,849
Client Advocacy	$10,184,066	$9,430,658	$11,486,480	$13,294,035
Buddy/Companion	$3,129,901	$3,264,191	$2,992,372	$2,020,461
Day/Respite Care	$6,391,426	$6,269,079	$5,699,174	$6,554,949
Counseling-Other	$3,827,319	$2,010,816	$5,012,287	$5,325,472
Other Support Services	$12,247,193	$8,561,050	$12,720,023	$15,995,264
Unallocated Funds:	**$0**	**$1,418,684**	**$780,737**	**$715,512**
Admin/PC/Prog Supp Subtotal:	**$33,580,053**	**$43,152,533**	**$44,855,367**	**$49,067,103**
Planning Council Supp	$7,340,653	$8,946,693	$9,842,950	$11,571,543
Program Support	$9,103,541	$13,496,984	$13,746,678	$14,774,261
Administration	$17,135,859	$20,708,856	$21,265,739	$22,721,299
Total Funds Allocated:	**$376,259,458**	**$429,377,900**	**$462,978,877**	**$481,979,597**

Updated by WC, 9/27/99. Note: 1999 allocations are anticipated.

Resource Allocation in a National HIV Care Program
49 (51 as of 1999) Metropolitan Areas of the United States by Service Category
1996-1999 Percentages

Service Category	*1996*	*1997*	*1998*	*1999*
Health Care Services Subtotal:	**48.20%**	**48.20%**	**44.00%**	**46.00%**
Medical Care	24.30%	24.90%	23.20%	24.80%
Dental Care	2.80%	2.80%	2.80%	2.90%
Mental Health	6.90%	6.10%	5.40%	5.90%
Substance Abuse	7.20%	6.40%	6.70%	7.60%
Home Health Care	4.90%	3.80%	2.20%	2.40%
Health Insurance Cont.	0.30%	0.30%	0.50%	0.40%
Hospice	0.90%	1.00%	1.20%	0.70%
Rehabilitation	0.30%	0.20%	0.00%	0.00%
Inpatient Personnel	0.00%	0.10%	0.10%	0.00%
Other Local Health Care	0.50%	2.70%	1.90%	1.40%
Medications:	**7.50%**	**9.60%**	**12.10%**	**8.60%**
Case Management:	**12.20%**	**11.40%**	**11.20%**	**11.70%**
Support Services Subtotal:	**23.20%**	**20.50%**	**22.90%**	**23.30%**
Nutrition/Food	4.30%	4.40%	5.30%	5.10%
Transportation	2.10%	2.10%	2.30%	2.30%
Housing	5.90%	5.50%	4.80%	4.90%
Emergency Assistance	1.40%	1.50%	2.20%	2.10%
Client Advocacy	2.70%	2.20%	2.50%	2.80%
Buddy/Companion	0.80%	0.80%	0.60%	0.40%
Day/Respite Care	1.70%	1.50%	1.20%	1.40%
Counseling-Other	1.00%	0.50%	1.10%	1.10%
Other Support Services	3.30%	2.00%	2.70%	3.30%
Unallocated Funds:	**0.00%**	**0.30%**	**0.20%**	**0.10%**
Admin/PC/Prog Supp Subtotal:	**8.90%**	**10.10%**	**9.70%**	**10.20%**
Planning Council Supp	2.00%	2.10%	2.10%	2.40%
Program Support	2.40%	3.10%	3.00%	3.10%
Administration	4.60%	4.80%	4.60%	4.70%
Total Funds Allocated:	**$376,259,458**	**$429,377,900**	**$462,978,877**	**$481,979,597**

Updated by WC, 9/27/99. Note: 1999 allocations are anticipated.

Winter 2000 Business Meeting and Advocacy Days

February 27–March 1, 2000

CARE NOW!

Reawakening the CARE Act in 2000

AMERICA'S RESPONSE TO AIDS

CAEAR

CITIES ADVOCATING EMERGENCY AIDS RELIEF

TABLE OF CONTENTS

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

The CAEAR Coalition
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February 27, 2000

Welcome CAEAR Coalition Members to the Winter 2000 Business Meeting and Advocacy Days!

Let me be the first to greet you to Our Nation's Capital.

The theme for this meeting is "Campaign to Reauthorize the CARE Act." The CAEAR Coalition's Executive Committee, staff, and contractors have worked to organize a powerful and effective few days for you here in Washington, DC. We will be advocating together for reauthorization of the CARE Act, and specifically to secure at least 61 Senate co-sponsors to assure easy passage on the Senate floor in the very near future.

May I suggest that you become familiar this program book? In it, you will find more details about our meeting, a list of who else is attending and where they're from, as well as information related to our advocacy work. Take a few minutes now and look over the program book - it is filled with much important material you will want to review before the meeting actually begins.

Those of you who are newer members or prospective members, we especially want to welcome you. Please make yourselves known to a member of the Executive Committee sometime while you are here. We are eager to meet you, and start to get to know you better.

Finally, I want to acknowledge all our members and donors who financially support the work of the Coalition. The message of our collective voice on behalf of people living with HIV disease would not be heard in Congress and the Administration without your assistance, your presence here in Washington, and your passion.

Thank you, and best wishes for a great Business Meeting and Advocacy Days,

Matthew

Matthew McClain
Chair

MEETING AGENDA

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

AGENDA

WINTER 2000
CAEAR COALITION BUSINESS MEETING & ADVOCACY DAYS
February 27-March 1, 2000

"Campaign to Reauthorize the CARE Act"

Radisson Barceló Hotel
2121 P Street NW
Washington DC 20037
tel 202-293-3100 fax 202-956-6693

Sunday February 27, 2000 Business Meeting Day 1	
Time	***Item***
8:00 am - 9:00 am	Registration
9:00 am - 9:30 am	Convene Meeting: Welcome and Introductions
9:30 am - 10:45 am	Reauthorization Campaign: Part 1
10:45 am - 11:00 am	Break
11:00 am - 12:30 pm	Coalition Updates: Incorporation, Fiscal, and Resource Development
12:30 pm - 2:00 pm	Lunch (on your own)
2:00 pm - 3:15 pm	Reauthorization Campaign: Part 2
3:15 pm - 3:45 pm	Special Presentation
3:45 pm - 4:00 pm	Break
4:00 pm - 5:00 pm	People with HIV/AIDS Caucus Meeting
5:00 pm - 6:00 pm	Title III Committee Meeting and Title I Cities Meeting
Starting at 6:00 pm	Hospitality Suite (hosted by San Francisco Community Clinic Consortium)

Monday, February 28, 2000 Business Meeting Day 2	
Time	*Item*
9:00 am - 10:00 am	People of Color Caucus Meeting
10:00 am - 10:30 am	Reconvene for Caucus/Meeting Reports
10:30 am - 10:45 am	Break
10:45 am - 12:00 pm	Reauthorization Campaign Financing: The Dues and Do's of CAEAR Resource Development
12:00 pm - 1:30 pm	Lunch (on your own)
1:30 pm - 3:00 pm	Preparation and Training for Advocacy Days (non-members may join)
3:00 pm - 3:15 pm	Break
3:15 pm - 4:15 pm	Regional Caucus Meetings
4:15 pm - 5:30 pm	Regional Reports and Wrap Up

Tuesday February 29, 2000 Advocacy Day 1	
Time	*Item*
9:00 am - 5:00 pm	Capitol Hill Advocacy Day Visits – your schedule to be provided
5:00 pm - 7:00 pm	Debrief – Capitol Hill location to be announced

Wednesday March 1, 2000 Advocacy Day 2	
Time	*Item*
9:00 am - 5:00 pm	Capitol Hill Advocacy Day Visits – your schedule to be provided

The Business Meeting is restricted to members only all day on Sunday and Monday morning. Non-members may join the meeting on Monday afternoon for the advocacy training. Prospective members who are sponsored by a member in good standing may participate throughout both days of the Business Meeting. Advocacy Days are open to anyone who has provided their name to the CAEAR office in advance and attends the training on Monday afternoon.

ROSTER OF PARTICIPANTS

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

CAEAR
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EMERGENCY AIDS RELIEF

ROSTER OF PARTICIPANTS

As of September 22, 2000

Winter 2000 Business Meeting and Advocacy Days

Radisson Barcelo Hotel
Washington, D.C.
February 27-March 1, 2000

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CAEAR EXECUTIVE COMMITEE

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

CAEAR COALITION EXECUTIVE COMMITTEE

(as of February 2000)

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POLICY COMMITTEE DOCUMENTS

Reauthorization Timeline
Reauthorization Talking Points
Title I and Title III FY 2001 Talking Points
Sample Letter for Mayors
Sample Floor Speech
Clinton Letter
Senate HELP Committee List
House Commerce Committee List

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

CARE Act Reauthorization Activity Likely Timeline

February 2000 - September 2000

Month	Senate Activity	House Activity	Important Related Activity	Grassroots Advocacy
February	Senate Recess February 11-21, 2000 Draft of Senate Reauthorizing Bill Released		Presidential Primaries Begin Release of Administration's FY 2001 Budget, February 7, 2000	Mobilize and Educate Title I Planning Councils about CARE Act Reauthorization Cities Advocating Emergency AIDS Relief (CAEAR) Coalition Meeting and Advocacy Days, Washington, DC, February 27-March 1, 2000
March	Senate Health, Labor, Education and Pensions (HELP) Committee Hearing and Mark-Up of CARE Act Reauthorization Bill, March 2, 2000	General Accounting Office Ryan White CARE Act Audit Report Release	Super Tuesday March 7, 2000 Presidential Primaries Continue	Senate Co-Sponsor Drive Begins Senate Co-Sponsor Drive Continues AIDSWatch Lobby Days, Washington, DC March 25-29, 2000
April	Floor Statements and Morning Business Speeches on CARE Act Floor Vote on Bill	Floor Statements/One Minute Speeches on CARE Act House Bill Introduced		On-Site Congressional Visits to Local AIDS Service Organizations House Co-Sponsor Drive
May		House Commerce Committee Hearing and Mark-Up of CARE Act Reauthorization Bill		
June		Floor Debate/Vote		
July				
August			Republican Convention July 31-August 3, 2000 Democratic Convention August 14-17, 2000	
September				Push for House-Senate Conference on Reauthorized CARE Act and Vote for Final Passage

Prepared by the San Francisco AIDS Foundation Public Policy Department, 415/487-3080, February 2000. All dates and activities are subject to change. Contact the SFAF Public Policy Department for the most updated information on dates and activities.

BUILDING ON A DECADE OF SUCCESS: REAUTHORIZE THE RYAN WHITE CARE ACT

Ten years ago, the US Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Public Law 101-381). The CARE Act was re-authorized in 1996 by unanimous vote in the House and by 97 to 3 in the Senate.

The Ryan White CARE Act represents the largest authorization of federal funds specifically designated to provide health and social services to low-income, uninsured or underinsured persons infected with HIV. For a decade, it has dramatically improved the quality of life for people living with HIV disease and their families, reduced use of costly inpatient care, and increased access to care for underserved populations, including people of color.

In 2000, Congress must reassert it leadership on AIDS by promptly reauthorizing the Ryan White CARE Act.

- **The HIV/AIDS epidemic remains an enormous health emergency in the United States.** More than 40,000 individuals in the U.S. are likely to be infected with HIV in 2000; the number of AIDS cases in the U.S. has nearly doubled during the last five years.

- **Dramatic decreases in HIV- and AIDS-related mortality** are the result of our nation's federal investment in HIV/AIDS prevention, care, treatment, and research. New drug therapies have brought hope and new challenges in the battle against the epidemic. Nonetheless, these drugs do not constitute a cure, and an effective vaccine is still years away.

- **Costs for effectively treating and providing care for people infected with HIV/AIDS are rapidly escalating.** A 1998 study found that the average cost of medical services per patient skyrocketed by 89.3% between 1995 and 1997. Comprehensive case management and better standards of HIV/AIDS care - though more costly - have promoted strict adherence to complex drug regimens and increased wellness for HIV/AIDS patients.

- **The CARE Act serves as the safety net** for underserved communities, including people of color, with little or no access to health care. The need remains great: A HHS HIV Cost and Services Utilization Study estimates that 250,000 to 300,000 individuals diagnosed with HIV infection currently receive *no* medical treatment. AIDS is the leading cause of death among African American men aged 25 to 44 and the second leading cause of death among African American women of that same age group.

- **The CARE Act reduces expensive inpatient hospitalizations and hospital-based services** and decreases the use of medical specialty care. Early diagnosis and treatment programs funded through the CARE Act remain an effective investment in people and in the health care system, saving substantial dollars by reducing admissions 30% nationally and up to 75% in some locales.

- **The CARE Act enables patients to return to normal functioning**, allowing many persons with HIV/AIDS to resume work and remain healthy, productive members of their community - thereby reducing their use of Medicaid and Medicare.

REAUTHORIZE THE RYAN WHITE CARE ACT THIS YEAR!

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

RYAN WHITE CARE ACT
TITLE I AND TITLE III
FY 2001 Appropriation

Title I of the Ryan White CARE Act *provides emergency assistance to the 51 metropolitan areas most heavily impacted by the AIDS epidemic. Title I supports comprehensive HIV health care and treatment for increasing numbers of uninsured and underinsured persons living with HIV/AIDS. Over 70% of people living with AIDS in the U.S. reside in Title I areas.*

Title III of the Ryan White CARE Act *provides direct grants to approximately 164 community-based clinics and public health providers in 36 states, Puerto Rico, and the District of Columbia. In 1999, these grants effectively furnished early-intervention and ongoing comprehensive HIV medical services on an outpatient basis to more than 96,000 persons with HIV/AIDS.*

The Cities Advocating Emergency AIDS Relief (CAEAR) Coalition urges and $89 million increase ($635.6 million total) in appropriations for Title I and a $46 million increase ($184.4 million total) in appropriations for Title III in FY 2001 to address the expanded need for these services.

Costs for effectively treating and providing care for people infected with HIV/AIDS have rapidly escalated.

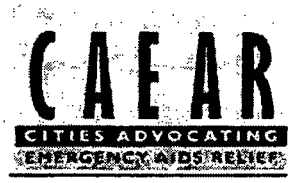
- Better standards of HIV/AIDS care that promote wellness and strict adherence to complex drug regimens have resulted in more frequent and longer medical visits. A 1998 CAEAR study estimated that from 1995 to 1997 the total number of patient visits to CARE Act providers increased by 55.3%. The average length of visits rose by 65%.
- The same 1998 CAEAR study found that the average cost of medical services per patient skyrocketed by 89.3%. This trend has not abated. Effective, comprehensive case management by providers has also necessitated higher costs for such.

HIV/AIDS in the United States increasingly affects communities of color, as well as economically-depressed and other underserved communities.

- Approximately one in fifty African American males in this country is infected with HIV/AIDS. Approximately one in 160 African American females in the U.S. is infected.
- Hispanic and African American women account for 77% of new infections among females in the U.S. Hispanic and African American men account for 58% of new cases among males.
- Though comprising only 13% of the U.S. population, African Americans represent 49% of deaths from AIDS, a death rate nearly ten times that of whites.

Comprehensive services directed at populations with high-risk and high-infection rates are an essential strategy for combating AIDS.

- The majority of individuals with HIV/AIDS in underserved communities are diagnosed also with substance abuse and/or mental illness. The Centers for Disease Control has noted that the link between substance abuse and HIV infection is especially pronounced in communities of color.
- The 1998 HHS National HIV/AIDS Treatment Survey found that one-quarter of those with HIV/AIDS are not receiving care that meets the guidelines established by HHS.
- The HIV Cost Services Utilization Study noted "substantial differences" in access to treatment and the quality of care for minorities and for the poor.
- Early diagnosis and treatment programs for underserved communities served by the CARE Act remain an effective investment in people and the health care system, saving substantial dollars by reducing hospital admissions 30% nationally and up to 75% in some locales.



Increased Funding for Title I Necessary in FY 2001

About three-quarters of people with HIV/AIDS reside in Title I areas. Funding, however, has not kept pace with the patient caseload of Title I providers.

- In 1997, Title I providers reported one million visits for medical services, 650,000 visits for substance abuse services, 450,000 visits for mental health services, and 1.25 million case management visits. With 40,000 new infections annually, these numbers continue to expand.
- Despite a growing number of people being served in each metropolitan area, the funds available from Title I for each Eligible Metropolitan Area (EMA) have merely remained flat. In FY 1994, Title I grants averaged $9.4 million per EMA. In FY1999, they averaged $9.3 million per EMA. In FY 99, 7 EMAs had reduced funding as compared to the previous year.

Title I is the major safety net for thousands of low-income persons living with HIV/AIDS who are ineligible for entitlement programs and would not otherwise receive HIV/AIDS treatment and care.

- About two-thirds of Title I clients are people of color. Thirty percent are women.
- Many people of color living with HIV/AIDS are burdened, too, by poverty, homelessness, substance abuse, mental illness, and/or other sexually transmitted diseases. Title I provides comprehensive case management and support services so that these other factors are effectively addressed in combination with direct care for HIV/AIDS.

Increased Funding for Title III Necessary in FY 2001

While escalating per-patient costs have consumed larger proportions of Title III provider expenditures, the caseload for Title III providers is also accelerating at a rapid pace.

- On average, each Title III provider is now serving over 585 clients annually, a significant increase over past years.
- Annually, over one-quarter of all persons served by Title III providers are new patients. Most new Title III patients (73% in 1997) are classified as moderately to severely ill, thereby requiring extensive and costly medical services.

Title III successfully reaches disparate, underserved communities in the United States.

- Title III is a primary means for targeting services to otherwise underserved communities and people of color. Over two-thirds (68%) of patients served by Title III are persons of color. Nearly 3 of every 10 persons served by Title III are women.
- Title III is the primary method for providing HIV care to rural areas. About half of Title III providers serve rural areas. Frequently, Title III providers are the *only* means by which many persons receive HIV testing and care.

The Cities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national grassroots organization advocating on behalf of people living with HIV/AIDS who depend on Title I and Title III of the Ryan White CARE Act for health care and support services. For further information, contact the CAEAR Coalition, 1413 K Street, NW Suite 700 Washington DC 20005, 202-789-3565, or The Sheridan Group, 1808 Swann Street, NW, Washington, DC 20009, 202-462-7288.

Prepared December 1999

SAMPLE LETTER

January 25, 2000

The Honorable Governor Gray Davis
State Capitol
Sacramento, CA 95814

Dear Governor Davis,

I am writing to express strong support for the federally funded Ryan White CARE Act which provides access to health care and related services to tens of thousands of people living with HIV and AIDS, and to request your leadership to ensure Congress moves quickly in re-authorizing this important legislation which expires on September 30, 2000.

Since 1990, the CARE Act has helped establish a comprehensive, community-based continuum of care for people with HIV and AIDS, including access to primary medical care, pharmaceuticals and support services. The CARE Act is essential in XXXXX efforts to provide services to uninsured and underinsured people with HIV disease who would otherwise have no access to care. Urban areas like XXXXX have had to shoulder nearly three-fourths of all AIDS cases putting an added strain on our already overburdened community-based public health care systems.

While new treatments have brought a welcome decline in AIDS death rates in XXXXXX and nationwide, the number of people living with HIV and AIDS has grown steadily over the last several years increasing the demand for services funded by the CARE Act. More than 4,200 people are living with AIDS in XXXX and an additional 10,000-14,000 are estimated to be infected with HIV. Increasingly, the newly infected are likely to be of color, heterosexual, poor, women, youth, substance users, the elderly, and homeless or marginally housed persons.

In 1996, Congress voted to reauthorize the CARE Act by a unanimous vote in the House of Representatives and a 97-3 vote in the Senate. As a long-time leader in the fight against HIV/AIDS, I ask for you're continued leadership to ensure that Congress reauthorize the Ryan White CARE Act this year. On behalf of the citizens of XXXXX, thank you for your assistance on this important issue.

Sincerely,

Mayor XXXXXX
City of XXX

SAMPLE FLOOR SPEECH

Hon. Lois Capps
In the House of Representatives
January 2000

- Mr. Speaker, I rise today to draw attention to the ongoing impact of the HIV/AIDS epidemic, and to underscore the success and importance of the Ryan White CARE Act in helping provide critical medical and social services to those affected by HIV in the 22nd Congressional District of California.

- Over 115,000 Californians have been diagnosed with AIDS and more than 70,000 of those have died. In San Luis Obispo County, more than 430 have been diagnosed and 207 have died. But the statistics don't tell about the individuals behind those numbers, like Sherrie and her son Sal.

- Sherrie discovered she had AIDS when she was hospitalized with pneumonia. Homeless with a child, uninsured and without enough money to get food, medical care or a roof over her and her sons head, she turned to the AIDS Support Network (ASN) of San Luis Obispo. ASN programs, funded in large part by Title II of the Ryan White CARE Act, helped provide Sherrie and her family with emergency rental vouchers while ASN staff helped Sherrie apply for Section 8 housing assistance to provide long-term housing support. Low on money, ASN provided Sherrie transportation to medical and dental appointments and helped her with payments for dental work. The agency provided her with food vouchers and nutritional supplements and Sherrie was able to get assistance with referrals for emotional support. As a result of this help, Sherry's health stabilized.

- Over the next several years, Sherrie worked hard to give back to those who had helped her and her family. She and her son told their story to thousands of students in local schools, helping raise awareness about HIV and AIDS. Sherrie recognized that by sharing her story with others she put a face on the epidemic that she knew would dispelled fears and stereotypes. She volunteered her time at ASN, helping with food drives to stock the ASN Food Bank, staffing outreach tables at the local Farmers Market and fielding questions from the local media. She taught others about how HIV affects women differently than men and how this disease had impacted her family. Thousands of peoples lives were touched by Sherrie.

- Eventually, Sherrie's health failed, her son became the primary caregiver and with the support of ASN, she and her family were able to get the support they needed. Despite her death, her son Sal just recently completed boot camp for the U.S. Navy and is currently serving aboard the U.S.S Boxer.

- Mr. Speaker, the Ryan White CARE Act makes a difference everyday in my district helping those who are in need, like Sherrie and her son. I look forward to working with my colleagues in this body to ensure that this important program is reauthorized this year and receives the critical funding that has helped shape our nation's response to this international pandemic.

THE WHITE HOUSE

WASHINGTON

December 29, 1999

Mr. Matthew McClain
Chair
The CAEAR Coalition
Suite 700
1413 K Street, N.W.
Washington, D.C. 20005

Dear Matthew:

Thank you for your letter regarding funding for the Ryan White Care Act in my fiscal 2001 budget. I appreciate knowing your thoughts on this important issue, and I've forwarded your correspondence to Sandra Thurman, of my National AIDS Policy Office, and Chris Jennings, my health care policy advisor.

As you may already be aware, in recent budget negotiations for the fiscal 2000 budget, we secured an increase of $183 million for the Ryan White CARE Act. As we work to develop a fiscal 2001 budget that meets the critical health needs of all of our citizens, I will keep your thoughts in mind. Best wishes.

Sincerely,

Bill Clinton

SENATE HELP COMMITTEE

Republicans

MEMBER	STATE	TITLE I	TITLE III
James Jeffords	Vermont	No	Yes
Judd Gregg	New Hampshire	No	Yes
Bill Frist	Tennessee	No	Yes
Mike DeWine	Ohio	Yes	Yes
Michael Enzi	Wyoming	No	No
Tim Hutchinson	Arkansas	No	Yes
Susan Collins	Maine	No	Yes
Sam Brownback	Kansas	No	Yes
Chuck Hagel	Nebraska	No	Yes
Jeff Sessions	Alabama	No	Yes

Democrats

MEMBER	STATE	TITLE I	TITLE III
Ted Kennedy	Massachusetts	Yes	Yes
Christopher Dodd	Connecticut	Yes	Yes
Tom Harkin	Iowa	No	Yes
Barbara Mikulski	Maryland	Yes	Yes
Jeff Bingaman	New Mexico	No	Yes
Paul Wellstone	Minnesota	Yes	Yes
Patty Murray	Washington	Yes	Yes
Jack Reed	Rhode Island	No	Yes

HOUSE COMMERCE COMMITTEE

Republicans

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Michael G. Oxley 2233 RHOB	Ohio	Yes	Yes
Michael Billirakis 2369 RHOB	Florida	Yes	Yes
Joe Barton 2264 RHOB	Texas	Yes	Yes
Fred Upton 2333 RHOB	Michigan	Yes	Yes
Cliff Stearns 2227 RHOB	Florida	Yes	Yes
Paul E. Gilmor 1203 LHOB	Ohio	Yes	Yes
James C. Greenwood 2436 RHOB	Pennsylvania	Yes	Yes
Christopher Cox 2402 RHOB	California	Yes	Yes
Nathan Deal 2437 RHOB	Georgia	Yes	Yes
Steve Largent 426 CHOB	Oklahoma	No	Yes
Richard Burr 1513 LHOB	North Carolina	No	Yes
Brian Bilbray 1530 LHOB	California	Yes	Yes

Republicans, cont.

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Charlie Norwood 1707 LHOB	Georgia	Yes	Yes
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Rick Lazio 2444 RHOB	New York	Yes	Yes
Barbara Cubin 1114 LHOB	Wyoming	No	No
James E. Rogan 128 CHOB	California	Yes	Yes
John Shimkus 513 CHOB	Illinois	Yes	Yes
Heather Wilson 226 CHOB	New Mexico	No	Yes
John B. Shadegg 430 CHOB	Arizona	Yes	Yes
Charles "Chip" Pickering 427 CHOB	Mississippi	No	Yes
Vito Fossela 431 CHOB	New York	Yes	Yes
Roy Blunt 217 CHOB	Missouri	Yes	Yes
Ed Bryant 408 CHOB	Tennessee	No	Yes
Robert Ehrlich 1714 LHOB	Maryland	Yes	Yes

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Rick Boucher 2329 RHOB	Virginia	Yes	Yes
Edolphus Towns 2232 RHOB	New York	Yes	Yes
Frank Pallone 420 CHOB	New Jersey	Yes	Yes
Sherrod Brown 201 CHOB	Ohio	Yes	Yes
Bart Gordon 2368 RHOB	Tennessee	No	Yes
Peter Deutsch 204 CHOB	Florida	Yes	Yes
Bobby L. Rush 2416 RHOB	Illinois	Yes	Yes
Anna G. Eshoo 205 CHOB	California	Yes	Yes
Ron Klink 2448 RHOB	Pennsylvania	Yes	Yes
Bart Stupak 2348 RHOB	Michigan	Yes	Yes
Eliot I. Engel 2303 RHOB	New York	Yes	Yes

Democrats, cont.

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Gene Green 2429 RHOB	Texas	Yes	Yes
Karen McCarthy 1330 LHOB	Missouri	Yes	Yes
Ted Strickland 336 CHOB	Ohio	Yes	Yes
Diana DeGette 1339 LHOB	Colorado	Yes	Yes
Thomas Barrett 1214 LHOB	Wisconsin	No	Yes
Bill Luther 117 CHOB	Minnesota	Yes	Yes
Lois Capps 1118 LHOB	California	Yes	Yes

DRAFT OPERATING PRINCIPLES AND PROCEDURES

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

Notice to CAEAR Members

In order to comply with IRS regulations, CAEAR filed two sets of articles of incorporation in the District of Columbia in late 1999. We filed to incorporate a 501 c 4 organization (to conduct lobbying) and a 501 c 3 organization (to conduct all other CAEAR business).

With the assistance of legal counsel, the next step is to prepare bylaws, which will be as generic as possible to comply with the law. Then CAEAR will proceed to obtain Employee Identification Numbers, bank accounts, and finally, IRS determination letters.

Once established in this manner, CAEAR can implement Operating Principles and Procedures that are consistent with the bylaws.

While in transition, however, the Operating Principles and Procedures can continue to be used to govern the organization.

CITIES ADVOCATING EMERGENCY AIDS RELIEF

CAEAR COALITION

MISSION STATEMENT

The CAEAR Coalition is a national membership organization with one goal: To better serve the critical needs of persons living with HIV/AIDS, through services provided by programs in Ryan White CARE Act Title I EMAs and by Title III grantees. This shall be accomplished by advocating for the integrity of the Ryan White CARE Act, for increased resources, and for the promotion of local decision making.

OPERATING PRINCIPLES AND PROCEDURES

A. MEMBERSHIP

1. Guiding Principles

- The CAEAR Coalition strives to ensure that all of the Coalition's decisions are preceded by local level discussions of issues that allow for full debate of divergent opinions. The goal of decision-making is to derive actions and positions that best reflect the diversity of interest.

- The Membership of the CAEAR Coalition is comprised of individuals and organizations that hold a variety of opinions and who represent both infected and affected communities.

- The CAEAR Coalition seeks to embrace and reflect diversity through its Membership. To meet this important objective, the Coalition endeavors to ensure that its Membership and governance includes consumers, and has racial, ethnic, gender, sexual orientation and regional diversity. To ensure that unduly restrictive diversity policies are not established numerically defined Membership quotas have been intentionally omitted from CAEAR Coalition Membership criteria.

- CAEAR Coalition Members agree to support the Coalition's mission statement and pay annual Coalition dues. Additionally, Members are encouraged to maintain a direct link to local CARE Act related concerns, EMA Planning Councils, **Title III grantees**, consumers, service providers, public health departments and representative groups.

2. ~~Eligible~~ Membership Requirements

Two categories of membership are available: Full Membership and Affiliate Membership:

Members **represent:**

- Title I **and III CARE Act grantees and Title I** Planning Councils ~~and CARE Act grantees~~
- People infected and affected by HIV/AIDS and their advocates
- Community based **health care and supportive service** organizations and **service** consortia that provide HIV services in Title I EMAs

Affiliate Members **represent:**

- **diverse industrial entities: pharmaceutical companies, individuals, corporations and institutions interested in health care, and in particular care to individuals with HIV disease. The Coalition's Executive Committee will apply the Affiliate Membership policy and dues structure.**

3. Membership Dues

~~Membership dues for the CAEAR Coalition are on an annual basis.~~ **The rate for membership dues for the CAEAR Coalition is set by the Executive Committee.** The Membership year shall commence ~~from the receipt of initial Membership payment and shall cover a period of 12 months from that date~~ on **October 1 and run until September 30th the following year.** Members shall be invoiced for dues at least 60 days prior to expiration of ~~its previous year membership~~ **the current membership year**. ~~To remain a Member in good standing, Membership dues (or acceptable payment arrangements – see Section A) must be received within 90 days of the Membership expiration date.~~

4. Member in Good Standing

A Member in good standing is an **organization/**~~eligible entities~~ individual ~~that have~~ which has paid dues in full or ~~have~~ has a written **payment schedule in place, cosigned by the Coalition's Executive Director and the Chair (or his/her designee) who will review the status of CAEAR Memberships to determine good standing status.** ~~reached an agreement with the Coalition's designated Membership administrator (e.g., Treasurer and/or Administrator of Federal Affairs) on a payment schedule. The Executive Committee reserves the right to review Membership on a case by case basis and provide determination of "good standing status". In such cases the criteria used to make a determination will also be provided. A Member in good standing will designate a representative. In the absence of that designated representative, a Member may authorize an alternate to participate in CAEAR meetings~~.

To remain a member in good standing, membership dues (or acceptable payment arrangements -- see above) must be received **within 30** days of the current membership expiration date.

The benefits of membership include: ~~a bimonthly Coalition newsletter,~~ regular legislative updates and action alerts, full participation in **CAEAR** Coalition meetings, technical assistance

(as available) and the ability to hold office. All dues paid become the property of the CAEAR Coalition.

~~Member dues payments by a single entity which exceed the annual dues requirements will be applied to the "angeling in" of other Members. Members who pay above the dues amount will be able to select a group to be "angeled in."~~

~~These Members may select a group of their own choice, or they may permit the Executive Committee to make the determination on the group to be "angeled in". The Executive Committee shall establish a waiting list for organizations that wish to become Members but are unable to raise dues. Excess Membership payments may be applied to these groups.~~

B. EXECUTIVE COMMITTEE

The governing body of the CAEAR Coalition is the Executive Committee. The Executive Committee will be comprised of up to **19** representatives as follows:

- **Four Officers:** Chairperson; Vice Chair; Treasurer; **Secretary (elected by a vote of the Membership)**
- **Six Regional Representatives** Southern, Southwest, Mid-Atlantic, Midwest, Northeast, and Northwest; **(elected by region caucuses)**
- **Two Title III representatives (elected by a caucus of Title III representatives)**
- Up to **seven** At-Large Members; (filled by the Executive Committee to fill demographic gaps) ~~Members in good standing may request to the Executive Committee that an At-Large seat be added to fill particular gaps identified.~~

Terms of office are from October 1 to September 30 **and run for the following terms:**

Chairperson - 2 year term
Vice Chair - **2**-year term **(staggered with term of Chairperson)**
Treasurer - 2 year term
Secretary – 2 year term
Regional and At Large Representatives – staggered two-year terms
Title III Representatives – staggered two-year terms

C. ELECTIONS

Election of Officers, Title III Representatives, and Region Representatives are held annually at the fall Coalition meeting.

- **Region Representatives are elected by vote of the region caucus members present.**
- **Title III Representatives are elected by vote of the Title II I Member caucus**

- **Officers are elected by utilization of an ad hoc nominating committee and balloting as detailed below.**
- **At-Large Members are appointed by the Executive Committee to fill demographic gaps**

~~Nominations will be accepted annually for open positions. Nominations will be left open until the next quarterly meeting, where elections will be held or the results from the Nominating Committee are announced. Anyone can nominate a Member in good standing. Members will have 30 days to contest Nominating Committee results. The results will be reviewed by the Chairperson for resolution. If a resolution cannot be reached, a separate ad hoc committee will be created to review grievances.~~

1. Ad Hoc Nominating Committee

At least two months prior to the **Fall** General Business meeting, during which elections will take place; the Executive Committee will appoint an Ad Hoc Nominating Committee. The Ad Hoc Nominating Committee will include an At-Large Member, a Regional Representative and an officer of the Coalition. The Ad Hoc Nominating Committee will seek nominations from Coalition Members prior to the business meeting to identify candidates interested in filling any **Officer** seats becoming vacant. **The full membership will be sent a list of those nominees prior to the Fall membership meeting. Balloting to fill those positions will be held at the Fall Coalition business meeting.**

2. Eligibility for Nomination

Nominees must agree to perform all duties and tasks as specified in the job description. Only the designated representative of a member in good standing at the time of the election shall be eligible for nomination and election to, or to hold a seat on the Executive Committee, including At-Large seats.

3. Filling vacancies between elections:

If a duly elected Member of the Executive Committee falls out of good standing during her/his term **or fails to adhere to the participation policies**, the Member will be asked to resign and an interim person will be appointed by the Executive Committee to finish the term. **Similarly, if a Member of the Executive Committee resigns, the Committee will appoint a Member in good standing to complete that unexpired term.**

D. DECISION-MAKING

The CAEAR Coalition is governed by consensus. The Coalition will strive to reach consensus on decisions relating to policy and other matters. **All business meeting attendees will be encouraged to participate in the consensus-building process.** In the event that the Coalition is unable to reach a consensus on an issue, the Coalition will make decisions using a formal voting procedure.

1. Voting

a. In Situ Voting

Only members in good standing can vote on CAEAR Coalition business.

Each member will designate a voting representative. In the absence of that designated voting representative at any membership meeting, a Member may authorize an alternate to participate and vote at CAEAR meetings. Each member in good standing will have one vote on any issue should a vote be required. **A member paying more than two memberships shall have a maximum of two votes.**

Prior to any decision, whether by consensus or vote, any Member can request a caucus. Caucuses may be called by region, state, EMA, special population or sub-population. In addition, caucus time will be built into each agenda. Agendas (noting caucus times) will be sent out in advance of all meetings. Additionally, Members are encouraged to hold Regional Caucuses between quarterly meetings.

b. Voting By Proxy

As stated in Section 1, members in good standing may send an alternate to participate in Coalition meetings. A member in good standing may authorize a proxy vote by providing the Coalition Chairperson with a written authorization granting another Member their voting rights.

2. Official Coalition Positions

Once the full Membership of the CAEAR Coalition takes a formal position on an issue, whether by consensus or majority vote of Members present or polled, the position will serve as the Coalition position until such time as it is affirmatively altered or revoked by the full membership. If a member in good standing wishes to reconsider an earlier decision or position, the decision to reconsider must be approved by a 2/3 majority of CAEAR members.

It is a tenet of the Coalition that members may not hold public positions that are inconsistent with the **CAEAR Coalition's mission** (as expressed in the Mission Statement). Members remain free to espouse divergent views on policy positions. Members who hold differing viewpoints on a policy issue, on which the Coalition membership has adopted a position, are requested to inform the Coalition **Executive Director or Chair**, of their differing policy position in writing at the earliest possible opportunity. The Coalition is then required to establish a forum in which the concern can be addressed by the Executive Committee of the Coalition or at the fall Coalition meeting depending upon the urgency of the issue. If and until a resolution of the two positions can be reached, the member is required to explicitly state in any public presentation of the position that the member is not representing the CAEAR Coalition's position.

In the event that there is insufficient time to poll the general Membership and a decision must be made, the Executive Committee shall have the authority to act on behalf of the Coalition. In such an event, it will be the responsibility of the Regional Representatives or staff to notify the Members on the issue and the position taken by the Executive Committee. Such notification will be delivered by fax and/or electronic mail within three working days of the Executive Committee decision.

Between bi-weekly Executive Committee conference calls, the Executive Committee empowers the Chairperson to make decisions, which are consistent with duly adopted policies and procedures on behalf, of-the Committee. Similarly, the Regional Representatives are empowered to make decisions for the region between monthly communications. In **the absence of the Chair,** ~~emergency situations~~, the Vice Chair is empowered to make decisions on behalf of the Chairperson

E. MEETINGS

The CAEAR Coalition full membership meetings shall, at a minimum, be held ~~quarterly.~~ **three times per year**. Meeting announcements**, registration forms** and agendas shall be distributed prior to the meeting date. The typical plan for meetings will be a ~~Saturday~~ briefing for new Members, or persons/**organizations** considering Membership, followed ~~by a networking opportunity~~ by the business meeting. **Unless determined otherwise by the Executive Committee, the Coalitions meetings are all day, closed meetings for paid members only.**

Persons considering Membership may attend one meeting as an observer with permission of the Chair of the Coalition or his/her designee. ~~The Coalition reserves the right to hold "Members only" meetings in order to conduct business, discuss and establish policy or determine strategy.~~ The business meeting will be followed by congressional advocacy days. When congressional visits are not necessary, the Coalition will strive to hold meetings in EMA's outside of the District of Columbia.

F. RESPONSIBILITIES OF MEMBERS AND REGIONAL REPRESENTATIVES

~~At a minimum,~~ Regional Representatives **serve as the Coalition Members' direct link with the full Coalition and** will have ~~monthly~~ **regular** contacts with Member constituents in their region, **will chair region caucus meetings (or teleconferences), and will assist region members with questions and concerns.**

All Members must establish some accessible link for communication with the CAEAR Coalition, and be able to reliably pass information to local planning councils and members of their community. It will be the responsibility of staff and the **Coalition Executive Director and/or** Executive Committee to pass information to Coalition members in a timely manner.

All "sign on" documents will be faxed to CAEAR members by the **Executive Director and/or** the Executive Committee. A minimum of 48 hours will be given for CAEAR Members to respond to the letter if the member wished to remove its name as a signatory.

G. STANDING COMMITTEES

Standing Committees of the Coalition include: Membership, Development and Public Policy. The Chair of the Coalition will appoint committee chairs from within the membership of the Executive Committee and may establish additional standing committees as needed. All members in good standing of the coalition are eligible to serve on standing committees.

H. CONFLICT RESOLUTION

The Regional Representatives are generally responsible for conflict resolution. The first step in conflict resolution is to contact your Regional Representative. Any conflicts in regards to the Coalition staff or consultants will be handled by the Executive Committee.

I. COLLABORATION WITH OTHER GROUPS

The CAEAR Coalition will work to establish collaborative relationships with national AIDS organizations that have CARE Act related goals. **These may include, national and regional** organizations and coalitions that advocate for federal HIV resources, and lobbyists representing various **organizations**, cities and counties that administer CARE Act funds.

J. COMMUNICATIONS

The Coalition Chairperson and the ~~Administrator of Federal Affairs~~ Executive Director are responsible for all day to day communications. The ~~Administrator of Federal Affairs~~ Coalition Executive Director will be responsible for communication with CAEAR staff, consultants and/or contractors, the Executive Committee Members, and regular communication with CAEAR members and constituents.

Attachments:

Affiliate Membership Policy
Executive Committee Participation Policy
Membership Assistance Policy
Scholarship Policy for Self-Disclosed PWAs

Draft Policies

Affiliate Membership Policy

The Resource Development Committee, in conjunction with the Membership Committee, shall recruit and select affiliate members. Affiliate members do not possess voting privileges.

Affiliate members can represent diverse industrial backgrounds. This membership group can include pharmaceutical companies, individuals, corporations, and institutions interested in health care, and in particular, care to individuals with HIV disease.

There shall be three categories of membership, each with specific privilege of membership: Bronze ($5,000), Silver ($10,000) and Gold ($25,000).

- Bronze includes participation in selected CAEAR Coalition events, including regional meetings.
- Silver includes participation in selected CAEAR Coalition events, including regional meetings and the option of participating in newsletter forums such as op-ed page submissions.
- Gold includes CAEAR Coalition events, including regional meetings, option of participating in newsletter forums such as op-ed submissions, and option of exchanging information with the Executive Committee on a variety of topics as well as meeting with the full Executive Committee at the Fall business meeting.

Membership Assistance Policy

Members are encouraged to raise additional funds to assist other entities to become new members. The decision regarding the expenditure of these funds remains with the donating member for 12 months. After this time period, the funds revert to the CAEAR Coalition and cannot be taken back by the contributing member. This policy shall be flexible for the first year of implementation. Affected members are encouraged to enter into dialogue with the CAEAR Treasurer and Executive Director to determine the disposition of existing membership assistance efforts before the first year of implementation has concluded.

Scholarship Policy for Participation of People Living with HIV Disease

To increase the participation of people living with HIV disease in its activities, the CAEAR Coalition will endeavor to allocate financial resources to be made available to provide scholarships to partially support the costs associated with travel and lodging for people with HIV who are willing to self-disclose their status.

Priorities for scholarship assistance are:

- Increase the participation of women.
- Increase the participation of people of color.
- Encourage persons from EMAs or Title III communities that have not routinely participated in meetings.
- Acknowledge organizations that have been strong supporters of the Coalition, e.g. those that have taken on additional work outside the quarterly meeting structure.

(continued)

Scholarship Policy, continued

Possible exceptions are:

- On a case-by-case basis determined by the Executive Committee, exceptions may be made to provide scholarships to non-member organizations only if the advocates represent a particularly strategic Congressional district or state.
- Registration waivers only for applicants who have reached the scholarship limit.

Procedures:

- The member organization must be a member in good standing, submit a maximum of one completed scholarship application per meeting, designate an individual applicant as the official representative of the organization, and provide the balance of travel support whenever possible unless the applicant is able to self-support.
- The applicant must self-disclose their HIV-positive status, be willing to attend both meeting day(s) and advocacy day(s), and be an official representative of a member organization.
- Executive Director and/or Membership Committee will review previous scholarship activity in the past to determine the history of previous recipients and eligibility for scholarship, limit scholarship support per member organization to a maximum of $1,000 per meeting (each case will be determined based on the specific needs of the member and the funds will be provided directly to the member organization to distribute), waive registration fees for scholarship recipients, and determine scholarship recipients as far in advance of the meeting as possible.

Executive Committee Participation Policy

During a fiscal year of the CAEAR Coalition, Executive Committee members must participate fully in a minimum of two-thirds of Executive Committee meetings, a minimum of two-thirds of full membership meetings, a minimum of two-thirds of advocacy days, and a minimum of two-thirds regular conference calls. These requirements will not be applied to special conference calls for advocacy support or additional conference calls. Each member of the Executive Committee must participate in at least one standing Committee.

The Secretary will inform the Executive Committee of an individual's lack of participation below these minimums. The Chair will issue an official warning to the individual. Recognizing that illness or other emergencies may impair an individual's ability to meet these requirements, the Chair of the Coalition must be notified in advance of absences whenever possible.

If a duly elected or appointed member of the Executive Committee falls out of good standing during his or her term for reasons of inadequate participation, the member may be asked by the Chair to resign, in which case an interim appointment will be made by the Executive Committee to finish the person's term.