

Associate Membership Application

About the Planning Council

The Central Florida HIV Planning Council is an integrated planning and advisory body to plan the organization and delivery of services provided under Part A and Part B of the Ryan White Treatment Extension Act of 2009.

Our Mission:

To improve the quality of life for individuals with HIV by responding to their existing and emerging needs and to provide educational and behavioral strategies to targeted populations, to reduce and prevent the spread of HIV.

Our Vision:

To ensure a quality continuum of care for all individuals and families infected with, affected by and at risk for HIV disease.

HIV Planning Council Committees

Service Systems and Quality: Responsible for overseeing and making improvements to the system of care from prevention to viral suppression, updating Standards of Care, assessing the efficiency of the Administrative Mechanism, monitoring of performance for clinical quality management activities, and coordinating with other federal recipients.

Needs Assessment and Planning: Responsible for the coordination of integrated planning, the annual Needs Assessment, special studies and town halls, reviewing data and management of data presentation, oversight of the Priority Setting & Resource Allocation processes, monitoring of expenditures, and approval of reallocations across service categories.

Public Relations & Marketing: Responsible for developing marketing and recruitment strategies, maintaining social media and website, providing public information and education, and coordinating community events and activities.

The Application Process

Complete this Application (be sure to sign the Statement of Member Commitment on page 2) and the Planning Council Information Sheet. Return to:

Planning Council Support
1940 Traylor Boulevard,
Orlando, FL 32804

Email: CFHPC@hfuw.org
Fax: (407) 835-0144

- Once received, your application will be reviewed to ensure it is complete. We will send an e-mail to confirm that we received the application.
- You will need to attend a Planning Council meeting and either a committee meeting or the Ryan White Community Meeting.
- After attending the two meetings, as mentioned above, your application will be reviewed by the specific committee(s).
- If your application is chosen, you will be contacted to confirm you wish to participate. If you agree, you will be recommended to the Orange County Chief Elected Official (CEO) for appointment to the selected committee(s). Generally, it takes about a month for the process to be completed after your appointment you will be expected to attend orientation.
- We will keep you updated on the status of your application.

Contact the Central Florida HIV Planning Council Support

Email: David.Bent@hfuw.org

Phone: (407) 835-0906

Fax: (407) 835-0144

Visit our website(s): www.ocfl.net/ryanwhite
<https://ryanwhitecfap.org/>

Gender:

- Female
- Male
- Transgender (M to F)
- Transgender (F to M)
- Other _____

I identify as (Check all that apply)

- Gay/Lesbian
- Bisexual
- Heterosexual
- MSM (Men who have sex with men)
- IDU (Intravenous Drug User)
- Other: _____

Current Age:

- 16 to 19 years
- 20 to 29 years
- 30 to 39 years
- 40 to 49 years
- 50 to 59 years
- 60+ years

Race/Ethnicity:

- White, not Hispanic or Latinx
- Black, not Hispanic or Latinx
- Asian/Pacific Islander
- Hispanic or Latinx
- American Indian/Alaska Native
- Multi-race (more than one)
- Other: _____

Are you currently or have you ever been a volunteer for any organization(s)

- HIV/AIDS Organization Board Member
- Other Organization Board Member

List Organizations and hours per week you volunteer:

Have you ever been convicted of a violent crime?

- No Yes

Describe why you wish to become a member of the Planning Council:

What skills, abilities and/or experience do you have that can be helpful to the Council?

- Life experience
- Planning experience
- Rules/Policy Development
- Education/Training Experience
- Budgeting/Financial Planning Experience
- Other - Describe: _____

Please indicate the committee for which membership is being requested:

- Service Systems & Quality PR/Marketing
- Needs Assessment & Planning

Can we assist you with any special accommodation (such as transportation assistance, wheelchair accessibility, or translation services) to help you participate fully on the Council?

- No Yes, I need assistance with: _____

Do you have any dietary restrictions/needs for meals served at meetings?

What languages do you speak?

- English Spanish
- Other: _____

Other Comments you would like to share:

The federally mandated categories of Planning Council participation that I am qualified to represent are: (please check ALL that apply)

- Healthcare Providers, including FQHC
- Community Based Organizations serving affected populations/AIDS Service Organizations
- Social Service Providers, including housing and homeless services providers
- Mental Health Providers
- Substance Abuse Providers
- Local Public Health Agencies
- Hospital Planning Agencies or Health Care Planning Agencies
- Affected Communities including PLWH and historically underserved groups of subpopulations
- Non-Elected Community Leaders
- State Medicaid Agency
- State Agency Administering the Part B Program
- Part D, or if none are operating in the area, representatives of area organizations with a history of serving children, youth and families living with HIV
- HIV/AIDS Treatment Modernization Act Grantees under Part C
- Other Federal HIV Programs (includes HIV Prevention programs)
- Representatives of/or formerly Incarcerated PLWH (release date must be within the past three years)

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CONFLICT OF INTEREST DISCLOSURE FORM

A conflict of interest in an actual or perceived interest in an action that will result or has the appearance of resulting in personal, organizational, or professional gain (i.e., members who serve as director, trustee, board member, salaried employee, subcontractor, or immediate family member*), or otherwise materially benefit from association with any agency receiving or seeking Ryan White Part A, Part B, Part C, Part D, and/or Part F funding is deemed to have an "interest" in said agency or agencies. Conflict of Interest does not refer to PLWH whose sole relationship to a Ryan White Part A, Part B, Part C, Part D, and/or Part F funded provider is as a client or serving as an uncompensated volunteer.

I am or have been affiliated within the last six (6) months with the following organization:

► Organization: _____
 Position: _____ From: _____ To: _____
 ► Organization: _____
 Position: _____ From: _____ To: _____

A member of my immediate family is or has been affiliated within the last six (6) months with the following organization:

► Name of Family Member: _____ Relationship: _____
 ► Organization: _____
 Position: _____ From: _____ To: _____
 ► Organization: _____
 Position: _____ From: _____ To: _____

I do not have an **ACTUAL** or **PERCEIVED** Conflict of Interest in any of the following Service Categories

I have an **ACTUAL** or **PERCEIVED** Conflict of Interest in the following Service Categories:

Actual	Perceived	Core Medical Services
		Outpatient Ambulatory Health Services (OAHS)
		AIDS Pharmaceutical Assistance
		Oral Health Services
		Early Intervention Services (EIS)
		Health Insurance Premium Assistance
		Medical Case Management
		Mental Health Services
		Medical Nutrition Services

Actual	Perceived	Support Services
		Substance Abuse Services
		Non-Medical Case Management
		Food Bank/Home Delivered Meals
		Housing Services
		Psychosocial Support (Peers)
		Medical Transportation
		Emergency Financial Assistance

The Conflict of Interest Form must be completed annually. Changes must be made within 5 days, when necessary.

**includes father, mother, son, daughter, husband, wife, brother, sister, mother-in-law, father-in-law, son-in-law, or daughter-in-law, as defined by Orange County Government*

Planning Council Information Sheet

Name: _____

Date: _____

NOTE: The HIV transmission categories on this form are those used by the Centers for Disease Control and Prevention (CDC) for HIV and AIDS reporting and monitoring. The information you provide on this form will be compared in aggregate to the epidemiology of the Orlando Service Area (OSA) to determine the reflectiveness of the Planning Council to that of the disease in the OSA. Please select the category that closely identifies your method of infection.

The information disclosed in this attachment will be held in the strictest of confidence as required by Federal and State regulations; only Planning Council Support Staff shall have access. The Membership Committee will be provided this information in aggregate format to monitor the reflectiveness of the Council as a whole as well as the reflectiveness of the un-aligned consumers.

My HIV status is

- Positive
- Negative
- _____ If yes, age at Diagnosis

- I **DO** self-identify* as HIV infected
- I **DO NOT** self-identify as HIV infected

The Health Council is required to track the mode of HIV transmission for Health Council Members who are positive. Please check the mode of transmission through which you contracted the disease.

- Men who have sex with men (MSM)
- Intravenous drug use (IDU)
- MSM/IDU
- Heterosexual
- Hemophilia
- Blood transfusion
- Perinatal
- Unknown/Not Reported

Applicants who wish to be counted as infected or be eligible to receive transportation assistance must provide Planning Council Support with documentation of their HIV status.

*Self-identify refers to publicly disclosing your status.

Applicants who wish to receive transportation to meetings and/or to be counted as positive are asked to bring documentation of their HIV status to their scheduled interview (i.e. a physician letter, lab results, etc.).