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 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 PSRA process, monitoring of expenditures, and approval of reallocations across service categories.

Membership: Responsible for recruitment and retention of members, ensuring parity, inclusion and representation, overseeing an open nominations process and providing member orientation and training. The committee will make recommendations for committee assignments.

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 Central Florida HIV 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, an interview will be scheduled.
- Your application will then be added to the pool of applicants.
- At each monthly Membership Committee meeting, the membership profile of the Planning Council is reviewed. If new members are needed, the committee will review all of the current applications.
- 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 Planning Council. Generally, it takes about a month for the process to be completed after the interview. You will also be encouraged to begin taking part in Planning Council activities. Once appointed you will be required 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/

Directions: Please review the first page before completing this application and be sure to sign the Statement of Member Commitment and the Planning Council Information Sheet.

Return the completed form to:

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Orlando, FL 32804
Email: CFHPC@hfuw.org
Fax: (407) 835-0144

All information in this application is confidential. It is seen only by the Planning Council Support staff and, as needed, by members of the Membership Committee and/or the Executive Committee during the application selection process.

Contact Information: *(Please Print)*

Name: _____

Address: _____

City: _____

State: _____Zip:_____

Email: _____

(Members are encouraged to create a separate and unique email address for planning council business due to Florida Sunshine Laws)

Primary phone: _____

Alternate phone: _____

Preferred way to be contacted between 9:00 am and 5:00 pm?

☐ Home phone ☐ Alternate phone ☐ email

Birthday: (month/day/year):_____

May we add you to our email list? ☐ Yes ☐ No

Agency/Organization Affiliation

(If applicable)

Job Title: _____

Organization: _____

PLEASE READ AND SIGN THIS SECTION

Statement of Member Commitment

If selected as a member of the Planning Council, I will commit to the following:

Check off each statement to show your commitment

☐ I confirm that, to the best of my ability, I am able to attend the regularly scheduled monthly Planning Council meetings. I will notify Planning Council Support in advance if I am unable to attend a meeting. **If you are not able to attend the monthly Council meeting on a regular basis, you cannot be considered for Planning Council membership.**

☐ I understand that membership on the Planning Council is a **two-year commitment**. I have considered my personal and professional commitments and do not foresee them as a barrier to my full participation on the Planning Council.

☐ I agree to abide by the Bylaws, Rules of Conduct and policies and procedures of the Planning Council.

☐ I agree to participate in Planning Council functions from beginning to adjournment.

☐ I understand I will need to prepare for meetings by carefully reading all pre-distributed materials.

☐ I understand when I make recommendations and/or decisions; I agree to consider the HIV community as a whole, rather than just special interests or my personal perspectives.

☐ I agree to disclose any conflicts of interest I may have relative to issues that come before the Council and/or Committees.

☐ I understand that Planning Council members are responsible for the recruitment of new members and members are encouraged to participate in outreach events.

☐ I agree to disclose any arrest and the resulting disposition of that arrest to the Planning Council, while a member of the Planning Council. Failure to promptly disclose the above information can lead to dismissal from the Planning Council.

☐ I certify that all statements and representations made in this application are true and correct

_____
Signature Date

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 Health 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 you would like to join:

☐ Service Systems & Quality ☐ PR/Marketing

☐ Needs Assessment & Planning ☐ Membership

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 Planning Council is required to track the mode of HIV transmission for Planning 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.).