Broward County HIV Health Services Planning Council
MEMBER UPDATE FORM

Please be aware that this application and all of the information you provide becomes a public record under Florida's Government in the Sunshine Law, Florida Statute, Chapter 119.01.

Dear Interested Party,

Please be aware that this application and all of the information once provided and submitted becomes a public record under Florida's Government in the Sunshine Law, *Florida Statute, Chapter 119.01*. Any information included in this application (for example, your HIV status or email address) becomes a public record and can be shared with the public, if requested. In addition, anything said during a Planning Council or Committee meeting is recorded and becomes public record. This information can also be shared with the public.

If your information is requested by an outside source, you will be notified, however the information is a public record and it may become part of a response to a public records request.

Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

Contact and Demographic Information

This is the update form for all HIV Planning Council and committee members. Please note any changes since submission of your application or last update form.

First Name: _____ **Last Name**:_____

Home Address:_____**Home Phone**:_____

City, State, Zip Code:_____**Cell Phone**:_____

Employer (if applicable):_____**Occupation/Title**:_____

Business Address:_____**Business Phone**: _____

City, State, Zip Code: _____**Fax:** _____

Home Email:_____ **Business Email:**_____

- **I prefer to receive phone calls and messages at:** ❑ Home ❑ Work ❑ Cell
- **I prefer to receive mail at:** ❑ Home ❑ Work
- **I prefer to receive email at:** ❑ Home ❑ Work
- **I prefer to receive HIVPC documents:** ❑ Electronically (via email) ❑ Hard copy (via mail)
- **What sex were you assigned at birth? (check one):**

  ❑ Male ❑ Female ❑ Decline to state
- **What is the current gender you identify with? (check all that apply):**

  ❑ Male ❑ Female ❑ Transgender (Male to Female) ❑ Transgender (Female to Male)

  ❑ Unknown ❑ Decline to state
- **Race (check all that apply):** ❑White ❑Black ❑Asian ❑Native Hawaiian/Pacific Islander

  ❑American Indian/Alaska Native ❑Other (Specify)_____
- **Ethnicity (check one):**

  ❑Hispanic/Latino ❑Non-Hispanic ❑Other (Specify)_____
- **Hispanic Subgroup (check one if any):**

  ❑Mexican ❑Puerto Rican ❑Cuban ❑Other (Specify)
- **Asian Subgroup (check one if any):**

  ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Other (Specify)
- **Native Hawaiian/Pacific Islander Subgroup (check one):**

❑Native Hawaiian ❑Guamanian ❑Samoan ❑Other (Specify)

- **Are you an employee, consultant, or board member to any Ryan White Part A Program funded agency?** ❑Yes ❑No
- **Do you self-identify as HIV positive?*** ❑ Yes, and I am open about my status ❑ No ❑ I do not wish to disclose

  **Disclosure of HIV status is not required for membership. Disclosure of HIV status in this application will become a part of the public record.*
- **If you self-identify as HIV positive, do you self-identify with any of the following risk factors?**

  ❑ Hemophilia ❑ Heterosexual (Straight) ❑ Intravenous Drug User (IDU) ❑ Perinatal Transmission (Mother to Child) ❑ Man who has sex with Men (MSM) ❑ MSM/IDU ❑ Blood Transfusion ❑ I don't know/Unsure ❑ I do not wish to disclose
- **Do you receive Ryan White Part A services?** ❑ Yes ❑ No ❑ I do not wish to disclose
- **If you self-identify as HIV positive, how old were you when you were diagnosed?**

  ❑0-12 years old ❑13-19 years old ❑20-29 years old ❑30-39 years old

  ❑40-49 years old ❑50-59 years old ❑60 years old or older ❑I do not wish to disclose

Categories of Membership (check all that apply)

- ❑ Health care providers, including federally qualified health centers
- ❑ Community-Based Organizations (CBOs) serving affected populations and AIDS Service Organizations (ASOs)
- ❑ 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 (people living with HIV/AIDS and underserved communities)
- ❑ PLWHA Recently Released from Jail or Prison or their representatives
- ❑ Non-elected community leaders
- ❑ Members of a Federally recognized Indian tribe
- ❑ Individuals co-infected with Hepatitis B or C
- ❑ State Medicaid agency
- ❑ Ryan White HIV/AIDS Program (RWHAP) Part B State agency
- ❑ RWHAP Part C grantees
- ❑ RWHAP Part D grantees
- ❑ RWHAP Part F grantees (including Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs), and dental program grantees)
- ❑ Housing Opportunities for Persons with AIDS (HOPWA) grantees
- ❑ Federally funded HIV prevention program grantees
- ❑ Veterans Health Administration representative

Please review and initial, indicating your acknowledgement of the following:

_____ I understand any information included in this application (for example, your HIV status or email address) becomes a public record and can be shared with the public, if requested.

_____ _____

Signature Date