Broward County HIV Health Services Planning Council
HIVPC MEMBERSHIP APPLICATION

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

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

Dear Interested Party,

Please be aware that this application and all 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.

Note: This application expires six (6) months from date of submission.
Mail, fax, or email your completed application to:

HIVPC Staff
Broward Regional Health Planning Council
200 Oakwood Lane, Suite 100
Hollywood, FL 33020
FAX: 954-561-9685
EMAIL: HIVPC@BRHPC.ORG

If you have any questions, please call: 954-561-9681

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Contact and Demographic Information

This is the application for membership on the Broward County HIV Health Services Planning Council (HIVPC). If you wish to apply for membership on the HIVPC, please complete the application below:

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:_____

Year of Birth: _____
(yyyy)

- 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) ❑ Blood Transfusion
❑ Perinatal Transmission (Mother to Child) ❑ Man who has sex with Men (MSM) ❑ 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

Recruitment Information

- How did you hear about the Ryan White Part A HIV Health Services Planning Council (HIVPC)?

❑ Through a service provider/agency
❑Email
❑Online/Facebook/Twitter
❑Friend/HIVPC member (HIVPC Member name): _____

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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

Committee Assessment

All HIVPC members are required to serve on at least one standing committee. Please rank the committees below to indicate your interest.

_____ Community Empowerment Committee (CEC): Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting, and resource-allocation processes. Functions as the outreach and education arm of the HIV Planning Council.

_____ Membership/Council Development Committee (MCDC): Recruits and screens applications based on objective criteria for appointment to the Council to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.

_____ Quality Management Committee (QMC): Ensures highest quality HIV medical care and support services for PLWHA by developing client and system-based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff and client training and education.

_____ Priority Setting & Resource Allocation Committee (PSRA): Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, and allocations.

_____ System of Care Committee (SOC): Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWHA in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

General Information

Describe the strengths, skills, and resources you have.

_____

_____

_____

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Describe your interest in becoming a member of the HIV Planning Council.

Describe how HIV/AIDS has impacted your life, either personally or professionally.

Please list any experiences you have related to community decision making or planning bodies.

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

_____I have received, read, and understand the HIV Health Services Planning Council Meeting Ground Rules and agree to abide by them at all Council and Committee meetings.

_____I understand that to qualify for nomination to the Planning Council I must be a member of a standing committee and attend an Orientation.

_____I understand that I must attend a post-appointment training within three (3) months of appointment to the Planning Council by the Broward County Board of County Commissioners. If I do not comply with this requirement, I could be removed from the Planning Council.

_____I understand that serving on the Council and at least one of its Committees will require at least five hours per month, and that excessive absence will result in my removal from the Council and/or Committees. I acknowledge that I am aware of the Planning Council Attendance Policy: a member is automatically removed from the Council if he/she misses three (3) consecutive Planning Council meetings or four (4) Planning Council meetings in a year in accordance with the County Ordinance.

_____If appointed, I would be willing and able to fulfill the responsibilities and functions of a member of the Broward County HIV Health Services Planning Council.

_____I am not an appointed member of any other Council or Board appointed solely by the Broward County Board of County Commissioners.

_____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 _____