Broward County HIV Health Services Planning Council
HIVPC MEMBERSHIP APPLICATION

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.

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 note that once you submit this application, all provided information becomes a public record under Florida's Government in the Sunshine Law (Florida Statute, Chapter 119.01). This means any details included in your application, such as your HIV status or email address, can be made available to the public upon request. Also, statements made during a Planning Council or Committee meeting are recorded and become public records, which can be shared with the public.

If an external party requests your information, you will be notified. However, since the information is a public record, it may be included in a response to a public records request.

Application Process

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, ext. 1244 or 1343

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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**: _____

- **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

- **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)

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- **Are you an employee, consultant, or board member of 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 – hivpc@brhpc.org
  ☐ Website - www.Browardhivpc.org
  ☐ Social Media /Facebook/Instagram/Twitter
  ☐ Friend/HIVPC member (HIVPC Member name): _____

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Required Planning Council Membership Categories (check all that apply)

PEOPLE LIVING WITH HIV & COMMUNITY

- ☐ Affected communities (people living with HIV/AIDS and underserved communities) *
- ☐ Non-elected community leaders
- ☐ Representatives of recently incarcerated people living with HIV
- ☐ Unaffiliated consumers

PUBLIC HEALTH & HEALTH PLANNING

- ☐ Local public health agencies
- ☐ Healthcare planning agencies
- ☐ State agencies**

HEALTH & SOCIAL SERVICES PROVIDERS

- ☐ Health care providers, including federally qualified health centers (FQHCs)
- ☐ Community-Based Organizations (CBOs) and AIDS Service Organizations (ASOs)
- ☐ Social service providers (including housing and homeless-services providers)
- ☐ Mental health treatment providers
- ☐ Substance abuse treatment providers

FEDERAL HIV PROGRAMS

- ☐ Ryan White HIV/AIDS Program Part B recipients
- ☐ Ryan White HIV/AIDS Program Part C recipients
- ☐ Ryan White HIV/AIDS Program Part D recipients *(or representatives of organizations with a history of serving children, youth, and families living with HIV)*
- ☐ Recipients under other federal HIV programs***

***** *Including people living with HIV, members of a federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and "historically underserved groups and subpopulations"*

****** *Including state Medicaid agency and agency administering the RWHAP Part B program*

******* *Including HIV prevention services; Ryan White HIV/AIDS Program Part F recipients, Housing Opportunities for People with AIDS (HOPWA), HIV Prevention)*

Committee Assessment

All HIVPC members must serve on at least one standing committee, but no more than two*. 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 various groups by engaging community resources to eliminate inefficiencies in access to services.

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General Information

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 attend at least three Council meetings.

_____ 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 absences as outlined in the Council By-Laws 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, my HIV status or email address) becomes a public record and can be shared with the public, if requested.

_____ _____
Applicant Signature Date

_____ _____
MCDC Chair Signature Date

_____ _____
HIVPC Chair Signature Date

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For PCS Staff Only

_____ _____

Date of HIVPC Approval Date of Appointment by the Broward County Board of County Commissioners

Review Minutes from: _____