



Partnership Membership Application

The Miami-Dade HIV/AIDS Partnership ("Partnership") was created pursuant to Ordinance No. 98-127 by the Miami-Dade Board of County Commissioners to serve as the planning body for several public programs providing medical and social support services to Miami-Dade County residents living with HIV/AIDS. Membership on the Partnership and its committees is open to people living with HIV or AIDS and other individuals.

**Our vision is to eliminate disparities and improve health outcomes
for all people living with or at risk for HIV/AIDS.**

If you . . .

- have a reputation of honesty, integrity and community service,
- possess the knowledge, skills and expertise relevant to the position for which you are applying or, as applicable, are employed in the field of expertise you wish to represent,
- are able to devote at least five (5) hours per month to Partnership and committee activities,
- are a resident of and a registered voter in Miami-Dade County,
- are not serving on more that two (2) County boards created by the Miami-Dade County Board of County Commissioners,
- agree to undergo a criminal background check conducted by the Office of the Mayor of Miami-Dade County, and
- agree to comply with any other federal, state and local requirements, including completion of an annual financial disclosure to the Miami-Dade County Supervisor of Elections Office,

. . . you are eligible to become a member of the Partnership!

Please keep this page for your records.

Partnership members conduct needs assessments, develop a comprehensive plan for HIV/AIDS, plan for care, treatment and housing services, interact with other community groups, set service priorities and allocate funds to meet the needs of People Living With HIV/AIDS in Miami-Dade County.

Members are appointed by the Mayor of Miami-Dade County upon recommendation from the Partnership. Terms on the Partnership shall not exceed two (2) terms of three (3) years each.

Within three months of appointment, members are required to complete the Miami-Dade HIV/AIDS Partnership New Member Orientation and Training and the Miami-Dade Commission on Ethics and Public Trust Mandatory Ethics Training.

The Partnership is funded through the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The purpose of the Act is to establish services and improve the availability of care for individuals and families with HIV/AIDS who would otherwise have no access to health care.

The Miami-Dade HIV/AIDS Partnership maintains at all times a fair and open nominations process for the Partnership and all standing committees. Membership is based on availability of positions.

Questions? Call Partnership Staff Support at (305) 445-1076 for assistance.

Partnership Membership Application

Contact and Demographic Information

Before completing this application, please be advised that the Office of the Mayor of Miami-Dade County conducts criminal background checks on all persons applying to its boards.

First Name: _____ Last Name: _____ Middle Initial: _____

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: _____

▶ Where may we contact you confidentially? Home Cell Email Work Other: _____

▶ Social Security Number: _____ - _____ - _____ * ▶ Date of Birth: _____

(*The County will not publicly disclose your Social Security Number and will take all steps to prevent such disclosure)

▶ Gender: Male Female

▶ Race/Ethnicity: White/Non-Hispanic Black/Non-Hispanic Hispanic Asian/Pacific Islander
 American Indian/Alaska Native Other (specify) _____

▶ Are you an officer, employee, representative or consultant to any Ryan White Part A Program funded provider? Yes No

▶ If appointed to the Partnership, on which committee would you *most* like to serve? *Note: Assignments are based on committee needs.*
 Care and Treatment Committee Housing Committee Prevention Committee
 Community Coalition Committee Medical Care Subcommittee Strategic Planning Committee

▶ Provide a brief statement explaining your interest in the Partnership and the HIV/AIDS planning process, including your background relative to HIV/AIDS (volunteer, professional, personal) and/or other relevant experience and expertise. You may also attach your resume or additional information.

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Categories of Membership

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 and Miami-Dade County Ordinance 98-27 mandate that the Miami-Dade HIV/AIDS Partnership include at least one member from each of the following categories of representation. Appointments are based on availability of seats. If you wish to apply for membership as a Representative of the Affected Community, please complete page 3 of this application, *Disclosure of Personal Health Information Authorization*.

Please select ALL categories you are eligible to represent. BSR staff assigns membership seats depending on availability and applicant's eligibility to fill the available seat.

- Community based AIDS service organization representative (**1 seat**)
- Former inmate of a local, state, or federal prison released from custody of the penal system during the preceding three years and had HIV disease as of the date of release, or a representative of HIV positive incarcerated persons (**1 seat**)
- Grantee representatives of other federal HIV programs including Ryan White Part F and HOPWA, if funded locally (**4 seats**)
- Health care provider representing a Federally Qualified Healthcare Center (**1 seat**)
- HIV prevention service provider (**1 seat**)
- Hospital or healthcare planning agency representative (**1 seat**)
- Housing, homeless or social service provider (**2 seats**)
- Local public health agency representative from the Florida Department of Health in Miami-Dade County (**1 seat**)
- Mental health provider (**1 seat**)
- Miami-Dade County Public Schools representative (**1 seat**)
- Non-elected community leader, not providing HIV health care services subject to funding under the Partnership (**1 seat**)
- Representative Co-Infected with Hepatitis B or C from the Affected Community (**1 seat**)
- Representative from agencies receiving grants under Ryan White Part C (**1 seat**)
- Representative from agencies receiving grants under Ryan White Part D, or from organizations with a history of providing services to children, youth, and families, if funded locally (**1 seat**)
- Representative of the affected community: This category includes: 1. Persons Living With HIV/AIDS (PLWHA) who are not affiliated or

employed by a Part A funded provider and are recipients of Part A services and 2. Caregivers of PLWHAs who represents historically underserved groups and subpopulations that reflect the demographics of the population within the affected community. **If you wish to apply for membership as a Representative of the Affected Community, please complete page 3 of this application, *Disclosure of Personal Health Information Authorization*. (15 seats)**

- Representative of a federally recognized Indian tribe as represented in the population from the affected community (**1 seat**)
- Ryan White Program Part A local grantee representative (**1 seat**)
- State government/Medicaid agency representative (**1 seat**)
- State government Ryan White Part B Program grantee representative (**1 seat**)
- State of Florida General Revenue grantee representative (**1 seat**)
- Substance abuse provider (**1 seat**)

SERVICE PROVIDERS You must be a current employee working in the service area for which you are applying, or you must be a board member of the provider agency to fill the following seats.

- Health Care Provider or Federally Qualified Health Center Representative
- HIV Prevention Provider
- Housing, Homeless or Social Service Provider
- Mental Health Provider
- Substance Abuse Provider



Partnership Membership Application

Disclosure of Personal Health Information Authorization

I, (print your full name) _____, understand that if I wish to be considered for membership or alternate status as a **Representative of the Affected Community** on the Miami-Dade HIV/AIDS Partnership, it is necessary to identify my HIV status. By signing this authorization, I willingly disclose my status.

THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT UNTIL REVOKED.

Please check "Yes" or "No" for each of the following statements:

- ▶ Yes No I am HIV positive.
- ▶ Yes No I am a recipient of Ryan White Part A services.
- ▶ Yes No I am a caregiver to an HIV positive person who is a recipient of Ryan White Part A services.

If I choose not to disclose my HIV status, I understand that I will be considered for membership in other membership categories, provided there is an open seat and I meet the qualifications for that seat.

I understand that this information will become public record and **may** be discussed in open, public meetings. The Florida Government in the Sunshine Law requires open discussion in a public forum. In addition, I further understand that by signing this release, I waive any exemptions of the information concerning my HIV status pursuant to Chapter 119.07 of the Florida Statutes. My status will be released to anyone who requests a copy of this document.

I further understand that I may revoke this authorization to disclose my HIV status, in writing, prior to my application being considered at the next Community Coalition Committee meeting. However, I understand that the information may have already been disclosed on the basis of this authorization.

I authorize the release and exchange of information about my HIV status among and between the Miami-Dade County Office of Grants Coordination, the Office of the Mayor of Miami-Dade County, the Miami-Dade County Office of the Inspector General, the Miami-Dade HIV/AIDS Partnership, the United States Office of Inspector General, the United States Department of Health and Human Services, and Behavioral Science Research Corporation.

Signature

Date

CANCELLATION OF DISCLOSURE AUTHORIZATION

I wish to cancel this Disclosure of Personal Health Information Authorization. I understand that I am entitled to a copy of this canceled Authorization.

Signature

Date



Partnership Membership Application

Miami-Dade County Voter Registration Verification

Members of the Miami-Dade HIV/AIDS Partnership and its committees must be permanent residents and registered voters of Miami-Dade County. A copy of your Miami-Dade County Voter Identification Card must be included with your application. An applicant has the right to not have his/her voter's registration information publicly disclosed if the applicant 1) is a participant in the Attorney General's Address Confidentiality Program for victims of domestic violence and stalking. See section [97.0585\(3\)](#) and sections [741.401-741.465](#), Florida Statutes. Contact the Attorney General's Office's Bureau of Advocacy and Grants Management at 850.414.3300 for instructions on how to become a participant; or 2) submits a written request to each agency that may have your information such as your address, photo, and date of birth. However, the applicant must fall within one of the statutorily designated classes of high-risk professionals.

COPY VOTER REGISTRATION HERE

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Statement of Commitment

As a Partnership member I agree to:

- ▶ Complete the Miami-Dade Commission on Ethics and Public Trust Mandatory Ethics Training within 3 months of appointment.
- ▶ Complete the Miami-Dade HIV/AIDS Partnership New Member Orientation and Training within 3 months of appointment, including completion of the Partnership Code of Conduct.
- ▶ Comply with any other federal, state or local requirements, including completion of an annual financial disclosure to the Miami-Dade County Supervisor of Elections Office.
- ▶ Abide by the Miami-Dade HIV/AIDS Partnership Bylaws and policies and procedures, including:
 - Attending monthly Partnership meetings from beginning to adjournment (approximately 2 hours).
 - Attending the monthly committee meeting(s) of the committee to which I am appointed from beginning to adjournment (approximately 2 hours).
 - Preparing for meetings by carefully reviewing all pre-distributed materials (approximately 1 hour).
 - Providing relevant information regarding HIV/AIDS service needs and priorities for planning and resource allocations.
- ▶ Treat Partnership members, staff and visitors with respect.
- ▶ Put aside special interests or personal perspectives and make recommendations for the good of the HIV/AIDS community as a whole.

I, (*print your full name*) _____, certify I have thoroughly read this application and will abide by the rules and regulations governing the Miami-Dade HIV/AIDS Partnership. I further certify that all the statements made in this application are true and correct.

Signature

Date (Application valid for 6 months from this date)

Please mail your completed application – including a current copy of your Miami-Dade County Voter ID Card – to Behavioral Science Research, Attn: Staff Support, 2121 Ponce de Leon Boulevard, Suite 250, Coral Gables, FL 33134; or send via fax to (305) 448-3325.

The Partnership's Community Coalition Committee will review and score your completed application. You are required to attend a Community Coalition Committee meeting to introduce yourself and state your interest in serving as a member. Upon recommendation from the committee, your application will go before the Partnership and you are required to attend a Partnership meeting to introduce yourself and state your interest in serving as a member. Members are appointed by the Mayor of Miami-Dade County upon recommendation from the Partnership and after passing the criminal background check.



Acknowledgement and Authorization for Criminal Background Check

As a condition of my application for appointment to the Miami-Dade HIV/AIDS Partnership, I understand that Miami-Dade County, through the Mayor's Office, will conduct a criminal background check on me to determine my eligibility to be appointed to the Partnership. By signing this Acknowledgement and Authorization I authorize Miami-Dade County, by and through the Mayor's Office, to access such information as may be necessary to complete a criminal background check.

I release from liability all persons and entities supplying such information. I indemnify Miami-Dade County against any liability which may result from making such requests. I agree that a fax or photocopy of this Acknowledgment and Authorization form with my signature will be accepted with the same authority as the original.

Signature of Applicant

Name of Applicant

Applicant's Social Security Number

Please fully write out your Social Security Number on the above line. The Mayor's Office will not process your application without a complete Social Security Number. The County will not publicly disclose your Social Security Number and will take all steps to prevent such disclosure.

Date

Please sign and return this Acknowledgment and Authorization form along with the completed application for membership on the Miami-Dade HIV/AIDS Partnership.