Membership Application for Representatives of the Affected Community

This is the application for membership on the Miami-Dade HIV/AIDS Partnership for Representative of the Affected Community (ROAC) seats. To apply for other seats, please complete the *General Membership Application.*

All members of County boards shall be permanent residents and electors of Miami-Dade County unless the Board of County Commissioners, by a two-thirds vote of its membership, waives this requirement, and should have reputations for integrity and community service. In addition, all board members should have demonstrated an interest in the field, activity or sphere covered by the board.

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.

Contact Information		
First Name:	**Middle Initial:**	**Last Name:**
Home Address:		
City:	**State: FL** *(Florida residency required)*	**Zip Code:**
Home Phone:	**Cell Phone:**	**May we text your cell phone?** ❑ Yes ❑ No
Home Email:		**Is this your preferred email?** ❑ Yes ❑ No, please use Business Email
Employer *(if applicable)*:		
Business Address:		
City: **State:** **Zip Code:**	**Business Phone Number:**	
Business Email:		**Is this your preferred email?** ❑ Yes ❑ No, please use Home Email

Demographic Information
Gender: ❑ Male ❑ Female ❑ Transgender Male ❑ Transgender Female ❑ Other *(please specify)*
Race/Ethnicity: ❑ White/Non-Hispanic ❑ Black/Non-Hispanic ❑ Hispanic ❑ Asian/Pacific Islander ❑ American Indian/Alaska Native ❑ Other *(please specify)*
Language(s) I speak: ❑ English ❑ Spanish ❑ Haitian Creole ❑ Other *(please specify)*
Date of Birth: (MM/DD/YYYY)

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Please complete this section.

Categories of Membership

Please select ALL categories you are eligible to represent.
Note: Recommended assignments are based on available seats.

❑ 15 Seats: Representative of the Affected Community who are:
- ✓ 13 Seats: People with HIV who are not affiliated or employed by a Ryan White Program Part A funded service provider ***and*** who receive of one or more Ryan White Program Part A services; and/or
- ✓ 2 Seats: Caregivers of people with HIV who represent historically underserved groups and subpopulations that reflect the demographics of the population within the affected community.

❑ Former inmate of a local, state, or federal prison who was:
- ✓ 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.

❑ Representative of a federally recognized Indian tribe as represented in the population from the affected community.

❑ Representative coinfected with Hepatitis B or C from the affected community.

Committee Assignments

If appointed to the Partnership, on which committee(s) would you *most* like to serve?
Note: Assignments are based on committee needs.

❑ Community Coalition Committee
❑ Housing Committee
❑ Care and Treatment Committee
❑ Prevention Committee
❑ Strategic Planning Committee
❑ Medical Care Subcommittee

❑ *Check here if you are currently a committee member.*

Please read and initial each statement.

Application Process	
Your initials here	I understand that if I am applying as a Representative of the Affected Community, I am required to complete the Disclosure of Personal Health Information Authorization (next page) identifying my HIV status.
Your initials here	I understand I am required to attend a Community Coalition Committee meeting to introduce myself and state my interest in serving as a member.
Your initials here	I understand the Partnership's Community Coalition Committee will review and score my completed application.
Your initials here	I understand that upon recommendation from the Community Coalition Committee, my application will go before the Miami-Dade HIV/AIDS Partnership and that I must attend that Partnership meeting to introduce myself and state my interest in serving as a member.
Your initials here	I understand the Miami-Dade HIV/AIDS Partnership is a Miami-Dade County Advisory Board and that members are appointed by the Mayor of Miami-Dade County upon recommendation from the Partnership and after passing the criminal background check.

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Please complete this section.

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

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Please complete this page.

Statement of Interest

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.

Ryan White Program Affiliation

Are you an officer, employee, representative, or consultant to any of the following Ryan White Program Part A/MAI funded subrecipients? ❑ Yes ❑ No

If YES, please check all that apply:

❑ AIDS Healthcare Foundation (AHF)
❑ Better Way of Miami
❑ Borinquen Health Care Center
❑ CAN Community Health
❑ Care 4 U Community Health Center
❑ Care Resource
❑ Citrus Health Network
❑ Community Health of South FL (CHI)
❑ Empower U Community Health Center
❑ Food for Life Network
❑ Jessie Trice Community Health System
❑ Latinos Salud
❑ Legal Services of Greater Miami
❑ Miami Beach Community Health Center
❑ MBCHC/St. Luke's Addiction Recovery Center
❑ New Hope C.O.R.P.S.
❑ Public Health Trust/Jackson Health System (all clinics)
❑ University of Miami

Areas of Expertise and Interest

Please check ALL populations in which you have expertise or interest:

❑ Black/African-American: ❑ Men ❑ Women ❑ Transgender
❑ Commercial sex workers
❑ Hispanic: ❑ Men ❑ Women ❑ Transgender
❑ Homeless population
❑ Immigrant population
❑ Men Who Have Sex With Men (MSM)
❑ Other Transgender/Transsexual populations
❑ Persons over 50 years old with HIV
❑ Substance use population
❑ Youth/Teens ❑ Other:________________________________

Please check ALL areas of expertise or interest:

❑ Communication, including social media
❑ Healthcare planning
❑ Financial resource allocations/budgeting
❑ Leadership/management
❑ Medical care and treatment
❑ Member recruitment
❑ Quality management/quality improvement
❑ PrEP and HIV prevention
❑ Social services (mental health, substance use, etc.)
❑ Other:____________________________________

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Please read and initial each Statement of Commitment.

General Requirements	
As a Miami-Dade HIV/AIDS Partnership Member, I agree to:	
Your initials here	Devote a minimum of four (4) hours per month to Partnership and committee activities, including: 1) Attending the Miami-Dade HIV/AIDS Partnership Meeting each month; 2) Attending the meeting(s) of my assigned committee(s) each month 3) Replying to meeting notices by confirming attendance with Partnership staff; 4) Preparing for meetings by reviewing agendas, minutes, and other materials distributed in advance in order to facilitate Partnership and committee business; and 5) As appropriate, submitting reports and/or feedback.
Your initials here	Serve on at least one (1) standing committee or subcommittee as suited to my interests, skills, and the needs of the Partnership.
Your initials here	Support the planning, needs assessment, and priority setting processes of the Partnership.
Your initials here	Contribute professional and personal expertise to further the work of the Partnership.
Your initials here	Uphold the goals, objectives, policies, and procedures of the Partnership.
Your initials here	Submit an annual Financial Disclosure Statement, required by 2-11.1(i) of the Code of Miami-Dade County.
Your initials here	Adhere to all other federal, state, and local civil rights laws and regulations.

Attendance Requirements	
As a Miami-Dade HIV/AIDS Partnership Member, I agree to:	
Your initials here	Comply with attendance requirements in accordance with Sections 2-11.39 and 2-1102 (G) of the Code of Miami-Dade County, as follows: 1) Five (5) absences from scheduled committee meetings in any County fiscal year (October 1 of the current year through September 30 of the year following) shall constitute grounds for removal. 2) A member who attends the meeting for less than 75% of the scheduled or actual duration of the meeting, whichever is less, is counted as absent from a meeting; 3) Absences which are due to Partnership business-related travel are not counted against the total of five (5) absences.

Training Requirements	
As a Miami-Dade HIV/AIDS Partnership Member, I agree to:	
Your initials here	Attend Partnership New Member Orientation and Training within the first three (3) months of joining.
Your initials here	Attend Miami-Dade County Advisory Board Member Ethics Training within the first three (3) months of joining.
Your initials here	Attend Miami-Dade County Mandatory Advisory Board Sexual Harassment Prevention Training, as available.
Your initials here	Comply with all other Partnership and/or Miami-Dade County Government training requirements.

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Please complete this section.

Acknowledgement and Authorization for Criminal Background Check

____
Name of Applicant

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.

____
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.

____	____
Signature of Applicant	**Date**

Revised 09/21/20

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Please complete this section.

Sign and Date

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.

Application valid for 6 months from this date.

Signature: **Date:**

Please mail your completed application to:

Behavioral Science Research Corporation (BSR)
Attn: Staff Support
2121 Ponce de Leon Boulevard, Suite 240
Coral Gables, FL 33134

Or send via email to hiv-aidsinfo@behavioralscience.com; or via fax to (305) 448-3325.

Your application will go before the Community Coalition Committee. You are required to attend a meeting of that committee to introduce yourself and state your interest in serving as a member. Upon recommendation from the Community Coalition Committee, your application will go before the Miami-Dade HIV/AIDS Partnership. You are required to attend a meeting of the Partnership to introduce yourself and state your interest in serving as a member. Following recommendation by the Partnership, your application will be forwarded to the Mayor of Miami-Dade County for appointment. You will be notified if/when your appointment is approved.

FOR OFFICIAL USE

Client #:

Date received: Date membership approved/denied: