MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee Membership Application

This is the application for membership on the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

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.

Please complete this page.

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)*

Other

Are you a registered voter in Miami-Dade County?
(Voter registration required)
❑ Yes ❑ No ❑ I'm not sure

Date of Birth:
(MM/DD/YYYY)

Are you an officer, employee, representative, or consultant to any Ryan White Program Part A funded subrecipient/service provider? See Page 3 for a list of Ryan White Program Part A Service Providers.
❑ Yes ❑ No ❑ I'm not sure

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee Membership Application

Please read and initial each Statement of Commitment.

General Requirements	
As a Miami-Dade HIV/AIDS Partnership Subcommittee Member, I agree to:	
Your initials here	Devote a minimum of two (2) hours per month to subcommittee activities, including: 1) Replying to subcommittee meeting notices by confirming attendance with Partnership staff; 2) Preparing for meetings by reviewing agendas, minutes, and other materials distributed in advance of a meeting, in order to facilitate the business of the subcommittee; 3) Attending meetings; and 4) As appropriate, submitting reports and/or feedback.
Your initials here	Allow Partnership Staff to access my voter registration information from the Florida Department of State Voter Information Lookup website.
Your initials here	Contribute professional and personal expertise to further the work of the subcommittee.
Your initials here	Uphold the goals, objectives, policies, and procedures of the subcommittee.
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	Submit an annual Medical Care Subcommittee Disclosure Form.
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 Subcommittee 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 a meeting for less than 75% of the scheduled or actual duration of the meeting - whichever is less - is counted as absent from that 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 Subcommittee 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	Comply with all other Partnership and/or Miami-Dade County Government training requirements.

Subcommittee Responsibilities	
As a Medical Care Subcommittee Member, I agree to:	
Your initials here	Attend the Medical Care Subcommittee Meeting each month, as scheduled.
Your initials here	Make recommendations to the Care and Treatment Committee regarding medical policies and procedures, quality management and improvement, Ryan White Program treatment guidelines and standards, and outcome measures, performance measures, and standards of care related to the delivery of Outpatient Medical Care, Prescription Drugs, and other core medical services.
Your initials here	Coordinate with State AIDS Drug Assistance Program (ADAP) and General Revenue to review formularies, expenditures, and utilization data patterns to make recommendations regarding the local Ryan White Part A Program Prescription Drug Formulary.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee Membership Application

If you are applying as a Person with HIV, please complete this page, *or*

Initial Here: I am not applying as a Person with HIV.

Disclosure of Personal Health Information Authorization

I, (*print your full name*) _____, understand that if I wish to be considered for membership as a Person with HIV 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.

I am HIV positive. ❑ Yes ❑ No

I am a recipient of Ryan White Program Part A services. ❑ Yes ❑ No ❑ I'm not sure

Ryan White Program Part A Service Providers

- 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

Your initials here	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.
Your initials here	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.
Your initials here	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 Medical Care Subcommittee meeting. However, I understand that the information may have already been disclosed on the basis of this authorization.
Your initials here	I authorize the release and exchange of information about my HIV status among and between the Miami-Dade County Office of Management and Budget-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:**

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee Membership Application

Please complete this page.

Seat Assignment

Please check all seats for which you qualify:

- ❑ ADAP Representative
- ❑ Advance Practice Registered Nurse (APRN)
- ❑ General Revenue Representative
- ❑ General Seats:_____
- ❑ Medical Case Manager
- ❑ Mental Health Provider
- ❑ Nurse
- ❑ Nutritionist
- ❑ Pharmacists
- ❑ Physician
- ❑ Physician Assistant
- ❑ Psychiatrist
- ❑ Substance Abuse Treatment Provider
- ❑ Representative of the Affected

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, including mental health and substance use
- ❑ Other:_____

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 committee to which you have applied. 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 committee, your membership will be accepted or denied.

Applications for the Partnership and other committees are available online and at regularly scheduled meetings. Please contact Partnership staff at (305) 445-1076 or hiv-aidsinfo@behavioralscience.com if you have questions or need assistance.

FOR OFFICIAL USE

Date received: Date membership approved/denied:

Revised 09/21/20

Medical Care Subcommittee Membership Application