



## Care and Treatment Committee Membership Application

This is the application for membership on the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee.

*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.*

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**Please complete this page.**

Contact Information			
<b>First Name:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>	
<b>Home Address:</b>			
<b>City:</b>	<b>State:</b> FL <i>(Florida residency required)</i>	<b>Zip Code:</b>	
<b>Home Phone:</b>	<b>Cell Phone:</b>	<b>May we text your cell phone?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Home Email:</b>		<b>Is this your preferred email?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, please use Business Email	
<b>Employer (if applicable):</b>			
<b>Business Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>Business Phone Number:</b>
<b>Business Email:</b>		<b>Is this your preferred email?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, please use Home Email	
Demographic Information			
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Other <i>(please specify)</i>			
<b>Race/Ethnicity:</b> <input type="checkbox"/> White/Non-Hispanic <input type="checkbox"/> Black/Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other <i>(please specify)</i>			
<b>Language(s) I speak:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Other <i>(please specify)</i>			
Other			
<b>Are you a registered voter in Miami-Dade County?</b> <i>(Voter registration required)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I'm not sure		<b>Date of Birth:</b> (MM/DD/YYYY)	
<b>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.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I'm not sure			



## Care and Treatment Committee Membership Application

**Please read and initial each Statement of Commitment.**

General Requirements	
As a Miami-Dade HIV/AIDS Partnership Committee Member, I agree to:	
<i>Your initials here</i>	Devote a minimum of two (2) hours per month to committee activities, including: 1) Replying to committee 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 committee; 3) Attending meetings; and 4) As appropriate, submitting reports and/or feedback.
<i>Your initials here</i>	Allow Partnership Staff to access my voter registration information from the Florida Department of State Voter Information Lookup website.
<i>Your initials here</i>	Contribute professional and personal expertise to further the work of the committee.
<i>Your initials here</i>	Uphold the goals, objectives, policies, and procedures of the committee.
<i>Your initials here</i>	Submit an annual Financial Disclosure Statement, required by 2-11.1(i) of the Code of Miami-Dade County.
<i>Your initials here</i>	Adhere to all other federal, state, and local civil rights laws and regulations.

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

Committee Responsibilities	
As a Care and Treatment Committee Member, I agree to:	
<i>Your initials here</i>	Attend the Care and Treatment Committee Meeting each month, including multiple dates during the Annual Needs Assessment.
<i>Your initials here</i>	Develop and implement all care and treatment planning.
<i>Your initials here</i>	Conduct an annual comprehensive Needs Assessment.
<i>Your initials here</i>	Establish or revise Ryan White Part A/Minority AIDS Initiative service priorities and complete the Priority Setting and Resource Allocation (PSRA) processes for each fiscal year.
<i>Your initials here</i>	Make recommendations to the Partnership on service priorities and use of other funds to target the areas of greatest need.
<i>Your initials here</i>	Make recommendations to appoint two (2) nominees to the Florida Comprehensive Planning Network's (FCPN) Patient Care Planning Group (PCPG).



## Care and Treatment Committee 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**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>▪ AIDS Healthcare Foundation (AHF)</li> <li>▪ Better Way of Miami</li> <li>▪ Borinquen Health Care Center</li> <li>▪ CAN Community Health</li> <li>▪ Care 4 U Community Health Center</li> <li>▪ Care Resource</li> <li>▪ Citrus Health Network</li> <li>▪ Community Health of South FL (CHI)</li> <li>▪ Empower U Community Health Center</li> </ul> | <ul style="list-style-type: none"> <li>▪ Food for Life Network</li> <li>▪ Jessie Trice Community Health System</li> <li>▪ Latinos Salud</li> <li>▪ Legal Services of Greater Miami</li> <li>▪ Miami Beach Community Health Center</li> <li>▪ MBCHC/St. Luke's Addiction Recovery Center</li> <li>▪ New Hope C.O.R.P.S.</li> <li>▪ Public Health Trust/Jackson Health System (all clinics)</li> <li>▪ University of Miami</li> </ul> |
|--|---|

<i>Your initials here</i>	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>Your initials here</i>	I understand that this information will become public record and <b>may</b> 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>Your initials here</i>	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 Care and Treatment Committee meeting. However, I understand that the information may have already been disclosed on the basis of this authorization.
<i>Your initials here</i>	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:** \_\_\_\_\_



# Care and Treatment Committee Membership Application

Please complete this page.

Areas of Expertise and Interest	
<p><b>Please check ALL populations in which you have expertise or interest:</b></p> <p><input type="checkbox"/> Black/African-American: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Transgender</p> <p><input type="checkbox"/> Commercial sex workers</p> <p><input type="checkbox"/> Hispanic: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Transgender</p> <p><input type="checkbox"/> Homeless population</p> <p><input type="checkbox"/> Immigrant population</p> <p><input type="checkbox"/> Men Who Have Sex With Men (MSM)</p> <p><input type="checkbox"/> Other Transgender/Transsexual populations</p> <p><input type="checkbox"/> Persons over 50 years old with HIV</p> <p><input type="checkbox"/> Substance use population</p> <p><input type="checkbox"/> Youth/Teens</p>	<p><b>Please check ALL areas of expertise or interest:</b></p> <p><input type="checkbox"/> Communication, including social media</p> <p><input type="checkbox"/> Healthcare planning</p> <p><input type="checkbox"/> Financial resource allocations/budgeting</p> <p><input type="checkbox"/> Leadership/management</p> <p><input type="checkbox"/> Medical care and treatment</p> <p><input type="checkbox"/> Member recruitment</p> <p><input type="checkbox"/> Quality management/quality improvement</p> <p><input type="checkbox"/> PrEP and HIV prevention</p> <p><input type="checkbox"/> Social services, including mental health and substance use</p> <p><input type="checkbox"/> Other: _____</p>

Sign and Date	
<p>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.</p>	
<i>Application valid for 6 months from this date.</i>	
<b>Signature:</b> _____	<b>Date:</b> _____

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 [mdcpartnership@behavioralscience.com](mailto:mdcpartnership@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 [mdcpartnership@behavioralscience.com](mailto:mdcpartnership@behavioralscience.com) if you have questions or need assistance.*

FOR OFFICIAL USE	
Date received: _____	Date membership approved/denied: _____