MIAMI-DADE HIV/AIDS PARTNERSHIP

Committee Membership Application

This is the application for membership on the committees and subcommittees of the Miami-Dade HIV/AIDS Partnership. The Partnership is the official Ryan White Program planning council and the Miami-Dade County advisory board for HIV prevention, care, and treatment. **This application consists of seven (7) pages and must be completed in full.**

All members of County boards shall be permanent residents and electors of Miami-Dade County. All members should have a reputation for integrity and community service; a demonstrated an interest in the field of HIV prevention, care, and treatment; and commitment to the board's requirements for membership.

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

Sex:
❑ Male ❑ Female

Language(s) I speak:
❑ English ❑ Spanish ❑ Haitian Creole ❑ Other *(please specify)*

Race/Ethnicity:
❑ White/Non-Hispanic ❑ Black/Non-Hispanic ❑ Hispanic ❑ Asian/Pacific Islander
❑ American Indian/Alaska Native ❑ 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

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Statements of Commitment

Please read and initial each Statement of Commitment.

General Requirements	
As a Miami-Dade HIV/AIDS Partnership Committee or Subcommittee Member, **I agree to:**	
Your initials here	Devote a minimum of two (2) hours per month to committee activities, including: 1) Replying to committee meeting notices; 2) Preparing for meetings by reviewing agendas, minutes, and other materials posted on the Partnership's website; 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 committee.
Your initials here	Uphold the goals, objectives, policies, and procedures of the committee.
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 Committee or 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 through September) 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 or 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.

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Committees and Subcommittees of Interest

1. **Check ❑ Yes or ❑ No for each committee or subcommittee of interest.**
2. **Read and initial each Statement of Commitment for the committee or subcommittee of interest.**

Community Coalition Roundtable	
I am applying for membership on the Community Coalition Roundtable: ❑ Yes ❑ No As a Community Coalition Roundtable Member, I agree to:	
Your initials here	Attend the monthly Community Coalition Roundtable.
Your initials here	Assist with recruiting potential Miami-Dade HIV/AIDS Partnership and Partnership Committee members from the community.
Your initials here	Encourage others from the affected HIV/AIDS communities to become more involved in Partnership and Committee activities.
Your initials here	Participate in the nominations process, including reviewing applications and nominating candidates for Partnership membership.
Your initials here	Assist with developing and implementing training and recruitment programs for the community to learn more about the Partnership and its activities.
Your initials here	Complete community outreach initiatives and report input and action items to the Partnership from community- based organizations and other groups.

Housing Committee	
I am applying for membership on the Housing Committee: ❑ Yes ❑ No As a Housing Committee Member, I agree to:	
Your initials here	Attend the monthly Housing Committee meeting.
Your initials here	Determine priorities and make funding and policy recommendations to the Housing Opportunities for Persons With AIDS (HOPWA) grantee for the use of HOPWA funds.
Your initials here	Bring knowledge and expertise on financing, developing, and managing special needs and affordable housing.
Your initials here	Coordinate planning efforts to address housing and housing-related services and identify opportunities to expand available housing for people with HIV in Miami-Dade County.
Your initials here	Engage key policymakers and stakeholders from both the public and private sectors in identifying additional resources and solutions to housing and housing-related service needs of people with HIV.

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Strategic Planning Committee	
I am applying for membership on the Strategic Planning Committee: ❑ Yes ❑ No As a Strategic Planning Committee Member, I agree to:	
Your initials here	Attend the monthly Strategic Planning Committee meeting or the Joint Integrated Plan Review Team meeting.
Your initials here	Review and oversee the Care and Treatment activities of the *Miami-Dade County Integrated Prevention and Care Plan for HIV/AIDS.*
Your initials here	Develop an annual report for the community, including the Miami-Dade County Board of County Commissioners, describing the Partnership's activities and the state of the epidemic in Miami-Dade County.
Your initials here	Assess the efficiency of the administrative mechanism for rapidly allocating funds to the areas of greatest need within the County.
Your initials here	Make recommendations to the Partnership regarding legislative and regulatory funding issues, and policy and rule changes related to HIV/AIDS and the Ryan White Program.

Prevention Committee	
I am applying for membership on the Prevention Committee: ❑ Yes ❑ No As a Prevention Committee Member, I agree to:	
Your initials here	Attend the monthly Prevention Committee meeting or the Joint Integrated Plan Review Team meeting.
Your initials here	Review and oversee the Prevention activities of the *Miami-Dade County Integrated Prevention and Care Plan for HIV/AIDS.*
Your initials here	Review all pertinent data required to prioritize HIV prevention needs and collaborate with the Florida Department of Health in Miami-Dade County on how to best obtain additional data and information.
Your initials here	Assess existing community resources to determine the community's capability to respond to the HIV/AIDS epidemic.
Your initials here	Identify unmet HIV/AIDS prevention needs within defined populations.
Your initials here	Prioritize HIV/AIDS prevention needs by target population and geographic areas, and propose high-priority strategies and interventions.
Your initials here	Make recommendations to appoint two (2) nominees to the Florida Comprehensive Planning Network's Prevention Planning Group.

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Care and Treatment Committee	
I am applying for membership on the Care and Treatment Committee: ❑ Yes ❑ No As a Care and Treatment Committee Member, I agree to:	
Your initials here	Attend the monthly Care and Treatment Committee meeting, including additional dates (as needed) during the Annual Needs Assessment.
Your initials here	Develop and implement all care and treatment planning.
Your initials here	Conduct an annual comprehensive Needs Assessment.
Your initials here	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.
Your initials here	Make recommendations to the Partnership on service priorities and use of other funds to target the areas of greatest need.
Your initials here	Make recommendations to appoint two (2) nominees to the Florida Comprehensive Planning Network's (FCPN) Patient Care Planning Group (PCPG).

Medical Care Subcommittee	
I am applying for membership on the Medical Care Subcommittee: ❑ Yes ❑ No As a Medical Care Subcommittee Member, I agree to:	
Your initials here	Attend the monthly Medical Care Subcommittee meeting.
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.

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HIV Disclosure

Meaningful involvement of people with HIV/AIDS is a cornerstone of Partnership and committee membership. Thank you for your participation.

I am applying for membership as a person with HIV. ❑ Yes ❑ No (Skip to page 7)

❑ I prefer 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. (Skip to page 7)

Ryan White Program

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/Food for Life Network
- Citrus Health Network
- Community Health of South FL (CHI)
- Empower U Community Health Center
- Jessie Trice Community Health System
- Latinos Salud
- Legal Services of Greater Miami
- Miami Beach CHC/St. Luke's Addiction Recovery Center
- New Hope C.O.R.P.S.
- Public Health Trust/Jackson Health System (all clinics)
- University of Miami

Attestations

Please read and initial each attestation below

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 committee or 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.

Disclosure of Personal Health Information Authorization

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

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 HIV status.

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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Areas of Expertise and Signature of Completion

Areas of Expertise and Interest	
Please check ALL populations in which you have personal or professional expertise or interest: ❑ People represented in minority populations ❑ People who are unstably housed or experiencing homelessness ❑ Men Who Have Sex With Men (MSM) ❑ People who are immigrants ❑ People with HIV over age 50 ❑ People between the ages of 13-24 years old ❑ People engaged in commercial sex work ❑ People with substance addiction ❑ Other:_____	**Please check ALL areas of expertise or interest:** ❑ PrEP and HIV prevention ❑ Medical care and treatment ❑ Member recruitment ❑ Leadership and management ❑ Healthcare planning ❑ Financial resource allocations and budgeting ❑ Social services (i.e., mental health, substance use, etc.) ❑ Communications, including web design and social media ❑ Quality management and quality improvement ❑ 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.	
Signature:	**Date:**

Application valid for 6 months from this date.

Please contact Partnership staff at (305) 445-1076 or mdcpartnership@behavioralscience.com if you need assistance.

Submit your completed application either by 1)mail, 2)email, or 3)fax:

1) Behavioral Science Research Corporation (BSR), Attn: Staff Support, 2121 Ponce de Leon Boulevard, Suite 240,Coral Gables, FL 33134
2) mdcpartnership@behavioralscience.com
3) (305) 448-3325

Upon receipt of your application, staff will contact you to review responses and next steps for membership. Following that review, your application will go before the committee or subcommittee to which you have applied. You are **required** to attend the meeting of that committee or subcommittee to introduce yourself and state your interest in serving as a member. Upon recommendation from that committee or subcommittee, your membership will be accepted or denied.

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