WEST CENTRAL FLORIDA RYAN WHITE CARE COUNCIL

Membership Application

Thank you for your interest in joining the Ryan White Care Council. The West Central Florida Care Council is a planning body of dedicated volunteers that are responsible for allocating Ryan White Funds to improve the lives of those infected and affected by HIV/AIDS. Typically, members serve a three year term.

The membership committee will score all applications. Questions will be scored based on your potential contribution to the Care Council and your general understanding of the Council's role. Scores will not be based on your writing ability. If there is more than one applicant for a specific seat, the applicant with the highest score will be selected. *Please pay attention to each question and make sure you answer all parts of a question. Also, please PRINT or TYPE your responses.* Members of the membership committee will also conduct an in-person interview with all applicants.

The entire application should take approximately 40 minutes to complete.

To schedule an interview or if you have questions please contact The Health Councils at (727) 217-7070 ext. 26.

Please mail or fax the completed application to:

The Health Councils
Attention: Nicole Brown
9600 Koger Blvd., Suite 221
St. Petersburg, FL 33702
Fax # (727) 570-3033

Rev 1/12/09

Applicant#___________

CONFIDENTIAL

Please be aware that the Care Council is a public body. You will receive mail / email and phone calls from the members and the staff.

Name____

Address____

City ______________________ State _________ Zip_____________

Home Phone (   ) __________ Work Phone (   ) ___________Fax (   ) ______________

Home E-mail:_______________________Work E-mail:______________________

Care Council composition must reflect the demographics of the HIV/AIDS epidemic and include representation from federally mandated categories. **Your responses will be kept CONFIDENTIAL** and will be available only to the authorized members of the Care Council, Council support staff and Grantee.

Gender: Male____ Female_____ Transgender__________

Date of Birth:____________________

Ethnicity:

Black (not-Hispanic) ___
Hispanic ___
White (not-Hispanic) ___
Asian/Pacific Islander ___
American Indian/Alaskan Native ___
Other Please specify: _________________

Category of Representation (check all that apply to you):

__Individuals living with HIV disease or AIDS
__Healthcare providers, including Federally Qualified Health Centers
__Community Based Organization (CBO) serving affected populations/AIDS Service Organization (ASO)
__Social Service Provider, including housing and homeless services provider
__Mental Health Provider
__Substance Abuse Provider
__Local Public Health Agency
__Hospital or other healthcare planning agency
__Affected Communities, including PLWH, Individuals co-infected with Hepatitis B or C and historically underserved subpopulations (people of color, migrant workers, women, homeless)
__Non-elected community leader
__State Medicaid Agency
__Ryan White State Part B Agency
__Ryan White Part C
__Ryan White Part D or organizations addressing the needs of children, youth, and families with HIV
__Grantees of other federal HIV programs such as HIV Prevention programs, AETC *(AIDS Education and Training Center)*, Dental, SPNS *(Special Projects of National Significance)*, and HOPWA *(Housing Opportunities for Persons with AIDS)*
__Representatives of/or formerly-incarcerated PLWH

Applicant#___________

1. **Describe your personal motivation for wanting to be a member of the Care Council.**

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2. **Please list any areas of expertise that you can bring to the Care Council.**
(Special skills, knowledge, training, life experiences, volunteer experiences, boards or commissions, especially those focusing on HIV issues)

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3. **Active member participation is vital to the Care Council.** You are committing to attend an orientation, monthly Care Council meetings, yearly retreats and to being an active member of at least one committee. Are you willing to commit the **<u>8-10 hours per month</u>** required to fully participate in the planning process?
   ___Yes ___No

4. Members are required to serve on **at least one committee**. Please indicate which committee(s) you are interested in joining.

   __Client Services

   __Health Services Advisory

   __Membership, Nominations, Recruitment and Training

   __Minority Advocacy (MAC)

   __Planning and Evaluation (P&E)

   __Resource Prioritization and Allocation Recommendations Committee (RPARC)

   __Rural Issues

   __Women, Infants, Children, Youth and Families (WICY&F)

I certify that all statements and representations made in this application are true and correct.

Signature_________________________________ **Date of Application** ____________

CONFIDENTIALITY OF MEMBER INFORMATION

The purpose of this Statement of Confidentiality is to emphasize that all information held in member records is confidential, with access governed by state and federal laws. Information that is confidential includes a member's address; medical, social and financial data; and services received. In addition, the fact that someone has had an HIV test is confidential, whether the result of that test is positive or negative. Data collection by interview, observations or review of documents should be conducted in setting that protects the client's confidential identity from unauthorized individuals. Member information will not be discussed outside the Care Council.

Section 384.29, Florida Statutes, addresses the need for special discretion in the handling of sexually transmissible disease information. Sexually transmissible diseases, by their nature, involve sensitive issues of privacy and all programs designed to deal with these diseases should afford privacy and confidentiality to the client.

Section 381.609, Florida Statutes, deals with confidentiality of HIV test results. There are penalties for violating this statute. These penalties range from disciplinary action by the agency to criminal charges.

I, ________________________________ understand and agree to abide by these confidentiality provisions.

Signature___________________________________ Date____________________

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CONFLICT OF INTEREST DISCLOSURE

Rules of law and ethics prohibit members from participating in and voting on matters in which they may have a direct/indirect financial interest. List any potential Conflicts of Interest (i.e., you or a significant other are a member of, employee of, or have a direct/indirect financial interest in an organization seeking/receiving Ryan White funds?

Agency	Relationship	Period of Affiliation

Signature___________________________________ Date____________________