PCHAP

PARTNERSHIP FOR COMPREHENSIVE HIV/AIDS PLANNING

Membership Application

All members must complete this Planning Group application. The purpose of this form is to provide the Administrative Office with needed information about Planning Group members. Please be aware that members will consistently be recognized as part of the Agency or other Representation that is selected in Section Four.

SECTION 1 - Member Profile

Please indicate where you would like to receive mail from the Planning Body:

Name:____

Company/Agency:____

Address:____

City:_______________________ State:_____ County:____________________ Zip:___________

Phone:_________________________________ Fax Number:____________________

Mobile Phone/Pager:____

E-Mail Address:____

SECTION 2 - Committee Selection

Please review the Committee descriptions below and choose which committee you would like to join. Further information about the Committees can be found in the PCHAP By-Laws.

All Members of PCHAP are required to select and participate on a Primary Standing Committee.

_______NEEDS AND RESOURCES COMMITTEE – The purpose of the Needs and Resources Committee is to conduct an annual Resource Inventory of all HIV/AIDS services; determine the needs of the clients and communities served by HIV/AIDS services through focus groups, surveys, interviews, and other acceptable methods; guide the Needs Assessment processes utilized by the Lead Agency for various required documents.

_______STANDARDS AND QUALITY COMMITTEE – The Standards and Quality Committee will set Standards of Service for the entire continuum of HIV/AIDS services, participate in the development and implementation of a quality management plan on those services funded by allocations from the Planning Group, and other HIV/AIDS services that choose to voluntarily participate in quality management plan development. The committee will work to enhance linkages and create a seamless system of all HIV services in Area 12. The goals of the committee will be to develop an annual action plan and evaluate the HIV services to all populations in Area 12 identified in the Comprehensive Needs Assessment and the Comprehensive Statewide Plan.

Name (Please Print):_________________________

Signature:____

Date:____

SECTION 3 - Conflict of Interest

A Conflict of Interest may occur when members who are professionally or personally affiliated with organizations that have, or might in the future request or receive funds for HIV/AIDS Prevention or Patient Care Activities or Services. This Disclosure Form has been adopted by the Planning Group and must be completed by all members in accordance with the By-laws of the Planning Group. If the only affiliation with an agency is as a client, then no Conflict of Interest exists.

By my signature below, I certify that:

1. I have read, understand and support Article Four, Section 8 of the Planning Group By-laws and have received, read, understand, and support the Conflict of Interest Policies & Procedures Statement.

2. Listed below is/are organization(s) with which I am presently affiliated. If in the future my affiliation(s) change(s) I will notify the Chair of the Planning Group.

Organization: ____

Title: ______________________ Period of Affiliation: ______________

Organization: ____

Title: ______________________ Period of Affiliation: ______________

Organization: ____

Title: ______________________ Period of Affiliation: ______________

Organization: ____

Title: ______________________ Period of Affiliation: ______________

(Please attach additional pages if necessary)

3. The following is true to the best of my knowledge and ability: Neither I or my immediate family have received or intend to receive any gratuities, favors, or anything of material value by a representative of a community based organization which might alter my ability to work objectively in the community planning process.

Name: ______________________ Signature: ______________________

(print)

Date: ______________________

SECTION 4: Agency or Other Representation

Please select up to three (3) categories of representation by placing a 1 next to the category that you primarily represent, a 2 for your secondary representation, and a 3 for your third choice.

_____ Florida Department of Health
_____ Volusia County Health Department
_____ Non-Minority Community Based Organization
_____ Minority Community Based Organization
_____ Non-Minority AIDS Service Organization
_____ Minority Board AIDS Service Organization
_____ Faith Community
_____ Other Non-Profit: ______________________
_____ Department of Corrections
_____ Academic Institution
_____ Research Center
_____ Local Government
_____ Public Schools
_____ Persons Living with HIV/AIDS
_____ HIV/AIDS Affected Community
_____ Other:______________________________

Primary and Secondary Expertise

Please select up to three (3) areas of expertise by placing a 1 next to the category of your primary expertise, a 2 for your secondary expertise, and a 3 for your third choice.

_____ Licensed Medical Professional
_____ Dentist / Oral Health Professional
_____ Mental Health
_____ Substance Abuse Treatment
_____ Case Management
_____ Quality Management / Evaluation
_____ Epidemiology
_____ Intervention Specialist
_____ Program Planning
_____ HIV/AIDS Infected Community (PLWHA)
_____ HIV/AIDS Affected Community
_____ Other: ______________________________

Planning Body Experience

Please indicate the number of years experience you have as a member of an HIV/AIDS Community Planning body or as part of a Consortium.

______HIV/AIDS Prevention Community Planning experience
______Ryan White Consortium experience
______Other Planning Body experience: ____________________________________

Additional Information

Please describe why you would be an effective representative:

____
____
____
____