

PCHAP

PARTNERSHIP FOR
COMPREHENSIVE
HIV/AIDS PLANNING

Dear New PCHAP Member,

Welcome to the Partnership for Comprehensive HIV/AIDS Planning (PCHAP)! Your interest and participation are invaluable to the community planning process; and your time and efforts are appreciated by everyone who is living with HIV or AIDS, affected by the disease, and those who are working to eradicate the disease in our area.

This orientation packet is intended to assist you in becoming a well-informed participant and effective planning body member. It is provided as a guide and reference tool, not only during your initial introduction to the planning process, but also throughout your membership. You are encouraged to use the notebook during partnership and subcommittee meetings as a convenient source for the organizational bylaws, definitions, and program explanations. You may also find it is helpful to include meeting notes and distributed materials within this cover as well; so that all of your meeting materials are organized in a single location.

We hope that your participation will be as rewarding to you as it is valued by everyone in the community who is affected by this disease.

Together, we can make a difference!

Sincerely,

The Steering Committee for the Partnership for Comprehensive HIV/AIDS Planning
(PCHAP)

PARTNERSHIP FOR COMPREHENSIVE HIV/AIDS PLANNING (PCHAP)

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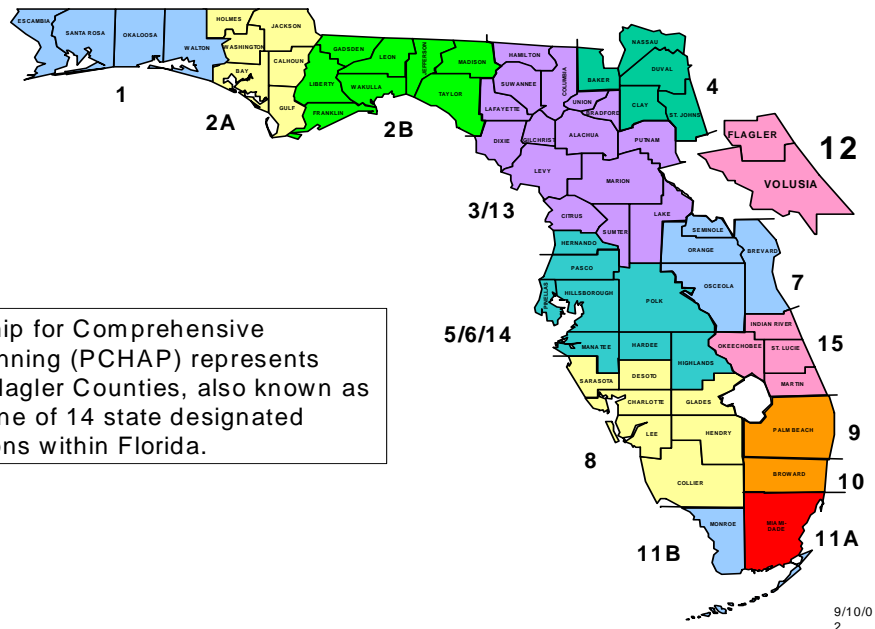
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Section 1:
Partnership for Comprehensive HIV/AIDS Planning

PCHAP

Introduction

Florida's Community Planning Partnerships



The Partnership for Comprehensive HIV/AIDS Planning (PCHAP) represents Volusia and Flagler Counties, also known as **Area 12**, as one of 14 state designated planning regions within Florida.

What is PCHAP?

The Partnership for Comprehensive HIV/AIDS Planning is a local planning body comprised of representatives from the community with extensive knowledge and expertise in HIV & AIDS. The Planning Body develops the Local Comprehensive Plan for the prevention, early intervention, and treatment of HIV and AIDS.

PCHAP operates under the Federal guidance and funding simultaneously. PCHAP is responsible for the planning of HIV/AIDS related patient care services as directed by the Health Resources and Services Administration (HRSA) for the Ryan White HIV/AIDS Treatment Extension Act.

What does PCHAP do?

The planning partnership works together to improve the accessibility, effectiveness, and quality of HIV/AIDS patient care services that are available in Volusia and Flagler Counties. To accomplish this, the members guide the community-wide needs assessments, inventory local resources, identify priority populations, determine service gaps, make recommendations on the allocation of funds and evaluate the effectiveness of the planning process. The majority of this work is completed by the PCHAP Committees.

A Brief History

In the spring of 2001, the former Ryan White Title II Volusia County AIDS Consortium (VFAC) and the HIV/AIDS Prevention and Education Planning Partnership (PEPP) finalized a merger joining the two entities as the partnership for Comprehensive HIV/AIDS Planning or PCHAP. The collaboration was intended to strengthen the comprehensive planning efforts of both groups, and has succeeded by producing many benefits throughout the community.

Some of the benefits that have been recognized by members, local providers, persons living with HIV/AIDS (PLWHA's), and the community include:

- An open forum to discuss the complete range of services from prevention through patient care and the importance of establishing and maintaining effective coordination.
- Training and mentoring the community to effectively participate in the planning process and to become advocates for HIV/AIDS services
- Improved overall parity, inclusion, and representation throughout the planning body

PCHAP Mission & Vision Statements

The mission of the Partnership for Comprehensive HIV/AIDS Planning (PCHAP) is: *To plan a comprehensive array of HIV/AIDS services spanning from prevention to early intervention and patient care through active, open, and inclusive community planning processes that emphasize delivery of quality and effective services to all clients and communities affected by HIV/AIDS within the boundaries of Volusia and Flagler Counties.*

The vision of the Planning Group is: *“Public and private individuals and agencies working cooperatively in an atmosphere of mutual trust, dignity and respect, to plan a seamless continuum of accessible, high quality services to all people of Area 12 affected by HIV/AIDS across the lifespan.”*

Membership

Anyone who is committed to the mission of the Planning Group is welcome to participate in its activities and committees. New members from the community are continually encouraged to join.

Active Voting Members of PCHAP are those who voluntarily choose to dedicate their time by:

- Completing a PCHAP application and returning it to the administrative office
- Selecting a Primary Standing Committee in which to participate
- Completing PCHAP Orientation
- Have attended two (2) of the last 3 planning body meetings

The PCHAP Bylaws indicate that:

The Planning Group membership should include organizations, public and private, with experience in HIV/AIDS service delivery and populations and subpopulations of persons living with HIV/AIDS (PLWHA) and/or persons affected by HIV/AIDS. In order to ensure diverse experience and input, members should be representative of, but not limited to, the types of organizations and expertise recommended in the most current guidance from both the Health Resources Service Administration (HRSA) and the Center for Disease Control (CDC). The Planning Group membership will consist of a minimum of 25% PLWHA or persons affected by HIV/AIDS.

Membership is founded on the tenets of Parity, Inclusion, and Representation (PIR):

Parity is when all members of the community planning group have the opportunity to acquire the skills and knowledge to participate in the planning process and have equal voice in voting and decision making. *(Everyone is given the same materials and opportunity to participate.)*

Inclusion is the assurance that the views, perspectives, and needs of all affected communities are included and involved in a meaningful manner in the community planning process. *(All affected communities are involved in the planning process in some meaningful way.)*

Representation is the assurance that those who are representing a specific community truly reflect that community's values, norms, and behaviors. *(The people at the table truly represent the community they claim to represent, not just personal interests.)*

For a further description of the PCHAP Membership see the Bylaws in the Appendices Section.

Committees

Listed below are the committees that make up the PCHAP and a description of how they function. All members **must** select and participate on one of the Primary Standing Committees in order to effectively participate in the voting and planning process. Committees meet as determined by the needs of the planning group.

Primary Standing Committees - Members must select a Primary Standing Committee on which to participate. The Primary Standing Committees are Needs & Resources and Standards & Quality. The Planning Group recommends that at least 25% of all Committees be people living with HIV/AIDS or affected by HIV/AIDS. Committees will meet as determined by the needs of the Planning Group.

The decisions of each committee will be based primarily on consensus building that takes place during duly called committee meetings at which a quorum (33%) of all current voting members is present. Should the voting members fail to reach a consensus within a reasonable amount of time as determined by the Committee Chair, the Chair may invoke Robert's Rules of Order, Newly Revised and call for a vote on the question to be determined. Any committee voting member may call for a vote on any specific issue by putting forth a motion. A simple majority of votes cast on any such issue shall be sufficient to decide the issue. The Committee Chair shall abstain from voting in such instances, unless the Chair's vote would either cause or break a tie, in which case the Chair may use their discretion in voting.

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

Secondary Committees - The Secondary Committees are Steering, Priorities & Allocations, Nominating and Ad-hoc. The Planning Group recommends that at least 25% of all Committees be people living with HIV/AIDS or affected by HIV/AIDS.

Steering Committee – The Chair of the Planning Group will serve as the Chair of the Steering Committee. The Steering Committee will consist of the Officers of the Planning Group and the Chairpersons of each committee. The Steering Committee will oversee the overall community planning process, maintain the bylaws, recruit new members, review conflict of interest claims and provide input to the Lead Agency as needed.

The Committee will review and update bylaws annually or as needed. The Committee will accept written requests for proposed bylaw changes from any active Planning Group member, review each request, draft changes, if any, and present the draft recommendations to the Planning Group for a final vote.

The Committee will also review and update annually, or as needed, the conflict of interest policy and distribute to all Planning Group members. The Committee will review potential conflicts of interest according to established policies and procedures at the request of any active Planning Group member.

Vacant Committee Chair positions will be selected and appointed by the Steering Committee in accordance with the by-laws. Nominating Committee Chair will serve as ex-officio on Steering Committee. In the event a vice-chair resigns or is no longer able to fulfill their duties, the Steering Committee will convene within 30 days or prior to the next Planning Group meeting whichever comes first, and a replacement will be selected from within its ranks.

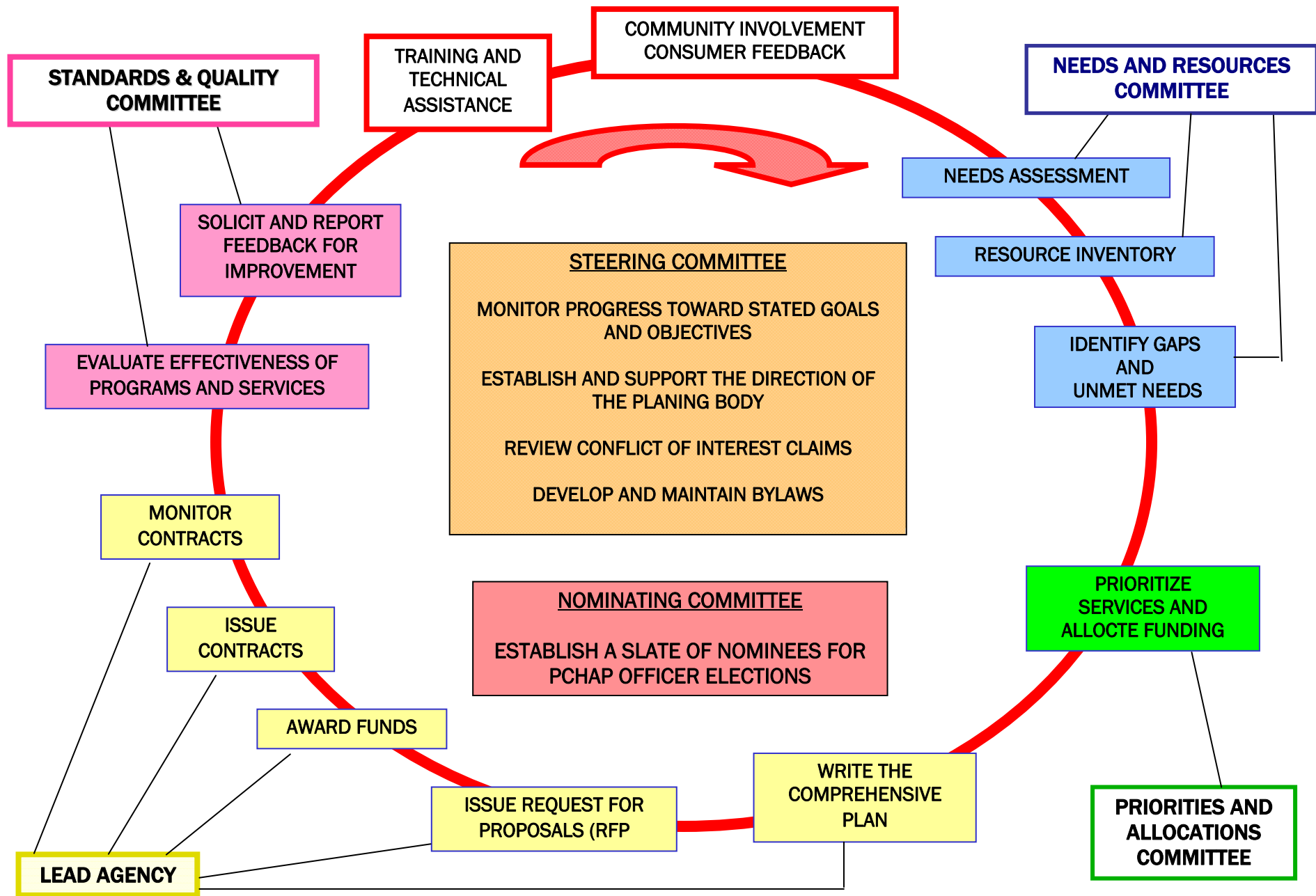
Priorities and Allocations Committee – The Priorities and Allocations Committee will conduct priority setting and allocation tasks as required by the Florida Department of Health for the Ryan White Part B funding, as well as by other funding sources. At least 25% of the Priorities and Allocations Committee members must be people living with HIV/AIDS. In determining priorities and allocations, the committee will rely on the work produced by the Needs and Resources Committee, which will have direct input from consumers, local AIDS services organizations and the Health Department. Planning Group Bylaws will guide Conflict of Interest, all committee members will review their Conflict of Interest statements to insure that they are current and all committee members will complete Conflict of Interest forms. All committee members should place the needs of the entire HIV population above any specific concerns. No more than one member from any agency may vote on the committee, these agency representatives will determine and notify the chair which member will vote. Committee members who are also Ryan White Part B service providers may not vote on their own service categories and are expected to treat all categories fairly. The chair will enforce the conflict of interest policy with the assistance of other committee members. Any committee member who believes a conflict of interest exists is expected to raise his/her concern immediately so that it may be resolved. Clients/consumers do not incur a conflict of interest merely by receiving services from an agency, but DO have a conflict if they are employed by, or a member of the Board of Directors of an agency. Committee members must be present to vote. Active Committee members are those who have attended two of the last three most recent meetings, including the current meeting. Recommendations to the full Planning Group from the Priorities and Allocations Committee will be subject to a strict “up or down” vote (approval or rejection) and may not be amended or modified by the full Planning Group and if rejected will be sent back to the committee.

Nominating Committee – The Nominating Committee is comprised of no more than five members to identify and present a slate of officer nominees to the Planning Group. The Nominating Committee will prepare a slate of officers to nominate for each duly held election by seeking qualified applicants from among current active voting members in good standing. Chair of the Nominating Committee shall be an active voting member selected by voting members during the Planning Group meeting and will serve as ex-officio on the Steering committee. The Nominating Committee convenes in October and prepares a slate of officers to present to the Planning Group in February.

Ad-Hoc Committees – The Chair may appoint Ad-Hoc committees as he or she deems necessary to address issues that do not logically fall under another committee, or issues that require immediate attention and cannot be addressed by another committee. In appointing such Ad-Hoc committees, the Chair will set a specific task to be completed with an initial timeline for the committee to report back to the Planning Group. Ad-Hoc committees tend to be short in their duration. During the time an Ad-Hoc committee is constituted, the Chair of that committee shall serve on the Steering Committee.

A complete listing of Planning Body and Committee requirements and responsibilities is provided in the Bylaws.

Cycle of Activities



Characteristics of Successful Members

A Planning Body member's success is determined not only by his or her business skills and experience, but also by his or her personality traits, or character. In his book, *Welcome to the Board* (1995, Jossey-Bass Inc. Publishers), author Fisher Howe identifies several characteristics of **successful, happy, and effective**

board members:

- They are honest
- They are enthusiastic
- They keep an open mind
- They are team players
- They tackle complex problems with relish
- They take an orderly approach to decision making
- They are competent
- They have a sense of humor

Common traits among "**problem**" board members include:

- Obsession with a single issue
- Always taking the "contrarian" view, just for show.
- Expounding on strongly held opinions that are rarely backed up by fact or research
- "Board-hopping" - or sitting on many boards/committees, but serving none well

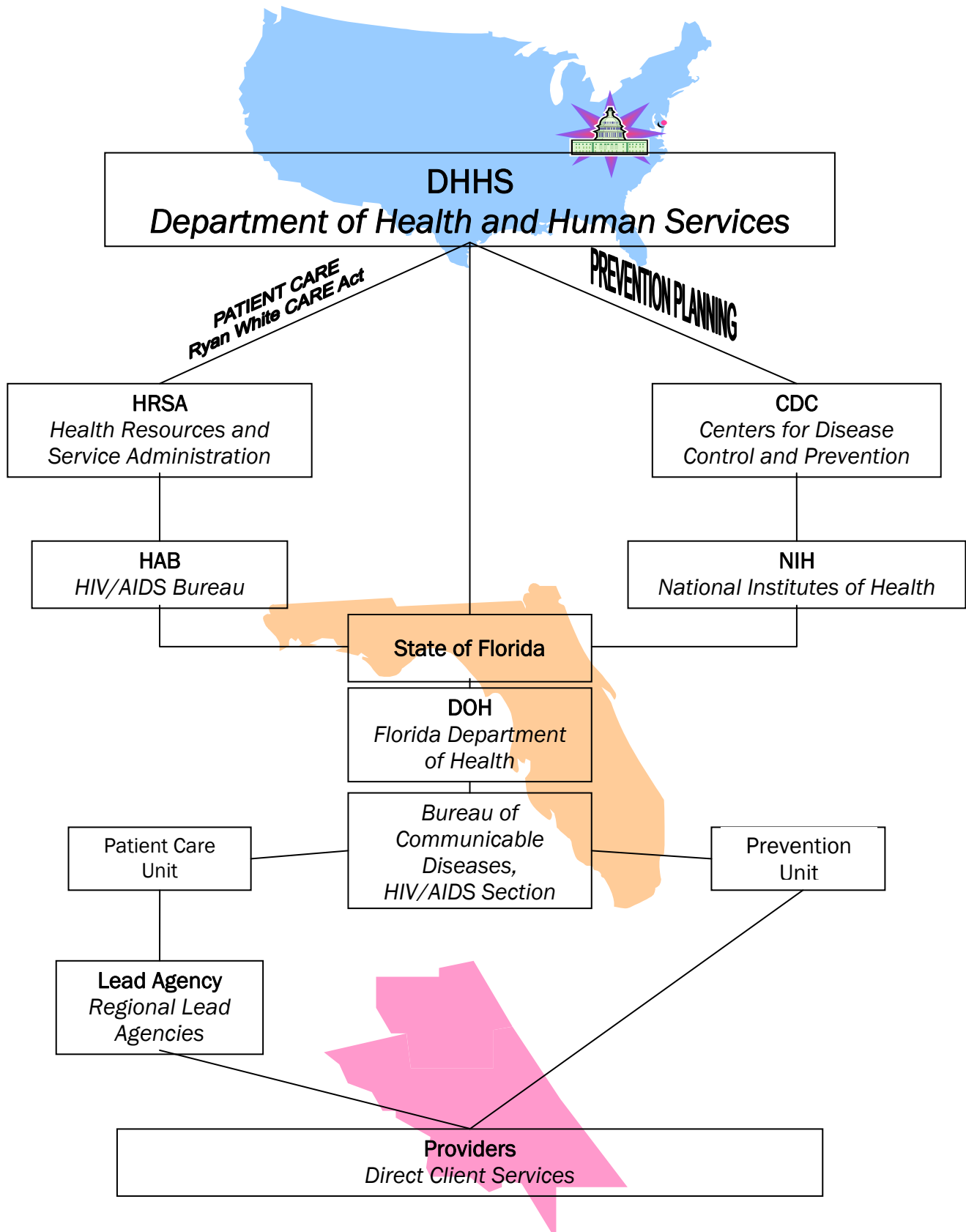
What PCHAP is...

- An advisory body that works to plan an effective network of HIV/AIDS services
- A place to work with others from the community to plan how to best deliver HIV/AIDS services to the people who need them most
- A place to share new programs, ideas, and information about HIV and AIDS services
- A place to network with representatives from HIV/AIDS services organizations and other community-based agencies
- A place to help build and shape Volusia/Flagler's HIV/AIDS service delivery system
- A place to help influence how the public funding that supports HIV/AIDS services is utilized in your community

What PCHAP is not...

- A place to highlight conflicts between clients, agencies, providers, or members
 - A place to gain public audience to grieve or complain about individual cases or providers
 - A support group
 - An Authority over any agency, provider, individual, or funding stream
-

Section 2:
HIV/AIDS Funding Diagram



Section 3:
Ryan White HIV/AIDS Treatment Extension Act of 2009

Overview

The purpose of the Ryan White HIV/AIDS Treatment Extension Act of 2009 revises and extends services under the Ryan White CARE Act Program. The Act will focus on life-saving and life-extending services and increased accountability for funding. The funding provides assistance to localities that are disproportionately affected by the Human Immunodeficiency Virus (HIV) epidemic for the development, organization, coordination and operation of effective, cost efficient systems for the delivery of essential services to individuals and families with HIV disease.

The main **goals** of the HIV/AIDS Treatment Extension Act of 2009 are to:

- Provide more funding flexibility to Areas of greatest need including both HIV & AIDS cases
- Target core life-saving medical services for those in need
- Improve quality of life for those affected by the epidemic.

CARE Act funded programs are the "**payor of last resort**." They fill gaps in care not covered by other resources. Most likely users of Ryan White services are people with no source of healthcare and those with Medicaid or private insurance whose care needs are not being met.

CARE Act funds are granted to local and State programs to provide primary medical care and support services; health care provider training; and technical assistance to help funded programs address implementation and emerging HIV care issues. Funds are intended to support services that enhance access to and retention in care. They may also be used for administration, including planning, quality management, and evaluation.

There are four **principles** that guide the CARE Act:

1. Revise care systems to meet emerging needs.
2. Ensure access to quality HIV/AIDS care.
3. Coordinate services with other health delivery systems.
4. Evaluate the impact of CARE Act funds and make needed improvements.

The Ryan White HIV/AIDS Treatment Extension Act includes 4 Parts summarized below.

PART A: Local Areas

Treatment Extension Act Part A, formerly Title I funds Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA). Metropolitan areas with more than 2,000 AIDS cases during the most recent five-year period and a population of at least 50,000 or more are eligible for funding as Eligible Metropolitan Area (EMA). Cities are considered a Transitional Grant Area if they have at least 1,000, but not more than 1,999 cumulative AIDS cases during the most recent five years and a population of 90,000 or more. The new method for determining eligibility for Part A funds dedicate priority to urban areas with the highest number of people living with AIDS while also helping mid-size cities and areas with emerging needs.

The new method for distributing Part A provides direct funding to metropolitan areas with the highest number of people who are HIV positive and also encourages outreach and testing which will get people into treatment sooner and save more lives. The CARE Act requires EMAs to establish Planning Councils, local bodies tasked with assessing needs, establishing a plan for the delivery of HIV care and developing priorities for the allocation of funds.

There are currently no EMA's or TGA's within Volusia and Flagler Counties, therefore, Part A funding is not available in Area 12.

PART B: HIV Care Grants

The Treatment Extension Act Part B, formerly known as Title II, provides for grants to States which enable each State to improve the availability of health care and support services for individuals and families with HIV disease. The **Partnership for Comprehensive HIV/AIDS Planning (PCHAP) operates through Part B funding**. Part B allows the use of money provided by the State for the following:

- Providing core life-saving medical services for those in need with HIV disease. Services may include outpatient, ambulatory health and support services such as case management, substance abuse treatment, mental health treatment, oral health, adherence services, health insurance continuation and pharmaceutical assistance.
- Establishing and operating HIV planning partnerships or Consortia, such as PCHAP, that are designed to provide a comprehensive continuum of care to individuals and families with HIV disease.
- Early Intervention Service to provide core medical services for individuals with HIV/AIDS in underserved populations.

In Florida, Part B funds are allocated among the regional planning partnerships or Consortia. The consortia must each submit the Comprehensive Plan for Area 12 to the State every three years and updating annually assuring that it has completed the following:

- Needs Assessment
- Developed a plan to meet identified needs
- Promoted coordination and integration of community resources
- Addressed the needs of all affected populations
- Assured the provision of comprehensive outpatient health and support services
- Arranged to evaluate the success and cost-effectiveness of the consortium in responding to service needs

PART C: Community Based Programs

Grants under Part C, previously known as Title III, are allocated directly to public and private organizations directly for:

- **Early intervention services** to reach people new diagnosed with HIV. Services include HIV testing, risk reduction counseling and case management.
- **Planning and Capacity Building Grants** to support organizations in planning for service delivery and building capacity to provide services.

PART D: Women and Children

Funds provided under Part D, formerly known as Title IV, provide family-centered and community based services to HIV positive children, youth, women and their families. Services include outreach, prevention, primary and specialty medical care, psychosocial services; also supports activities to improve access to clinical trials and research. There is one Part D funded provider that has extended services into Area 12.

PART F: AETC and Dental Reimbursement

Part F authorizes funding for:

- **AIDS Education Training Center (AETC) Program**
- **HIV/AIDS Dental Reimbursement Program**

The AIDS Education and Training Centers (AETC) Program supports a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers treating persons with HIV/AIDS. It serves to increase the number of healthcare providers who are effectively educated and motivated to counsel, diagnose, treat, and medically manage PLWHA's.

The HIV/AIDS Dental Reimbursement Program supports access to oral health care for HIV+ individuals by reimbursing dental educational programs for non-covered costs incurred by providing such care. Recipients may be dental schools, post-doctoral dental education programs such as hospital based residencies, and dental hygiene education programs. By offsetting the costs of non-covered HIV related dental care; this program addresses the dual goals of improving access to oral health care and training new generations of dental providers to manage the oral health of HIV+ persons.

Minority AIDS Initiative

The Minority AIDS Initiative, created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States, provides funding across several Department of Health and Human Service Agencies to strengthen organizational capacity and expand HIV-related services in minority communities. The Minority AIDS Initiative provides funding for activities to evaluate and address the disproportionate impact of HIV/AIDS and disparities in access, treatment, care, and outcome on racial and ethnic minorities. The new law recognizes that HIV/AIDS has had a devastating impact on racial/ethnic minorities in the U.S. African Americans accounted for 49 percent of all HIV/AIDS cases diagnosed in 2005.

The new law codifies the Minority AIDS Initiative as part of the Ryan White program in the Public Health Service Act under Title XXVI and provides funding for activities to evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities.

Through Parts A and B, metropolitan areas and states will be able to compete for funding to address disparities in access, treatment, care, and health outcomes. HRSA expects to award funds through the Minority AIDS Initiative for Part A and B programs in August 2007.

The Minority AIDS Initiative funding for Parts C, D and F (AIDS Education and Training Center) programs will continue to be awarded at the same time as programs receive their other Ryan White funds.

Special Projects of National Significance (SPNS)

The Special Projects of National Significance (SPNS) Program funds innovative models of care and supports the development of effective delivery systems for HIV care. It serves to advance the knowledge and skills in the delivery of health and support services to underserved populations. SPNS is considered the research and development arm of the Ryan White CARE Act and provides the mechanism to:

1. Assess the effectiveness of individual models of care;
2. Support innovative program design; and
3. Promote replication of effective models.

Section 4:
Other Patient Care Programs

AIDS Drug Assistance Program (ADAP)

What is ADAP?

The AIDS Drug assistance Program (ADAP) is funded by the Ryan White HIV/AIDS Treatment Extension Act (formerly known as the Ryan White Emergency CARE Act) and the State of Florida Legislature. The Florida ADAP works through the 67 County Health Departments in the State. The mission of the ADAP Program is to provide life-saving medication, disease management training and information to eligible HIV positive individuals in a cost effective way.

Who is Eligible for ADAP?

As funds allow, the ADAP program is open to individuals living in Florida who meet all of the following requirements:

- Must be determined eligible for the Ryan White Patient Care Programs
- Does not qualify for any other program that reimburses for medications
- Must have viral load/CD4 count completed within the last 6 months.
- Must have a prescription that is
 - Written by a doctor who is licensed to prescribe medication in the State of Florida
 - Less than 6 months old
 - Must be included on the ADAP formulary

AIDS Wrap-Around Pilot Project AWAPP

The AIDS Drug Assistance Program Wrap-Around Pilot Program (AWAPP) is a Florida Department of Health program for Medicare Part D clients who are eligible for ADAP and have income between 135% - 150% of the Federal Poverty Level. AWAPP provides assistance in the payment of out of pocket Medicare Part D pharmacy and deductible expenses.

In order to qualify for AWAPP, individuals must be determined eligible for the Ryan White Patient Care Programs, must have Medicare Part A, B, and D coverage, qualify for the Low Income Subsidy (LIS) through the Social Security Administration and does not have Medicaid or a secondary private health policy,

PCHAP has no jurisdiction or planning responsibilities for the ADAP Program.

ADAP Premium Plus Insurance

The ADAP Premium Plus Insurance Program is a component of the ADAP program created to assist eligible ADAP clients who have prescription insurance coverage such as Medicare Part D, employer sponsored private insurance, or limited plans with out-of-pocket costs.

AIDS Insurance Continuation Program (AICP)

What is AICP?

The AIDS Insurance Continuation Program, a component of ADAP Premium Plus, preserves the private health insurance coverage of low-income Floridians who cannot afford to pay their private health insurance premiums, deductibles and co-payments. The AICP ensures continuity of medical care to insured low-income Floridians living with HIV/AIDS at a significant cost savings to the state of Florida.

If you cannot afford to pay your monthly health insurance premiums because you are no longer able to work or because you are a low-income working person or parent, you may be eligible for AICP.

Who is Eligible for the AICP?

As funds allow, the AICP Program is available to individuals who meet all of the following requirements:

- Must be determined eligible for the Ryan White Patient Care Programs
- Diagnosis of AIDS, or HIV positive with at least one symptom since you tested positive
- Currently covered by private health insurance
- Annual gross income (before taxes) not more than 400% of the most current Federal Poverty Level (FPL) guidelines
- Willing to sign all AICP forms

What will AICP pay for?

- Assists with Insurance premium payments, up to \$750/month, to your employer or insurance company for medical, dental, and vision coverage.
- Group, COBRA, Family and Individual policies qualify co-payments (\$100/month limit) to your medical, dental and vision.
- Deductibles (\$2,500/year limit)
- Based on availability of funds

PCHAP has no jurisdiction or planning responsibilities for the AICP Program.

Housing Opportunities for Persons with AIDS (HOPWA)

What is HOPWA?

The State Housing Opportunities for Persons with AIDS (HOPWA) program is funded through a grant from the Department of Housing and Urban Development (HUD) to provide resources for meeting the emergency and temporary, short-term housing needs of persons with living HIV and AIDS. The Florida Department of Health, the grantee, receives the funding from HUD then contracts with the local lead agencies to serve as project sponsors.

The State HOPWA Program funds are used for short-term rent, mortgage and utility payments to **prevent** homelessness. The HOPWA program goals are to provide short-term interventions that help maintain a stable living environment for households experiencing a financial crisis as a result of issues arising from their HIV/AIDS condition. The program seeks to foster long-term solutions to housing problems for individuals receiving this time-limited housing assistance.

Who is eligible?

The State HOPWA Program is available to individuals who meet the following requirements:

- Must be determined eligible for the Ryan White Patient Care Programs
- Must have proof of HIV positivity
- Must have an income that is 80% of the median income
- Must have a documented HIV-related need for housing assistance

Program benefits:

- Short-term rent/mortgage payments
- Short-term utility payments
- Case management services associated with housing

PCHAP has no jurisdiction or planning responsibilities for the HOPWA Program.

Section 5:
HIV/AIDS Prevention Community Planning

Definition of HIV/AIDS Community Planning & Prevention

The Centers for Disease Control and Prevention (CDC) define HIV Prevention Community Planning as “a collaborative process by which health department’s work in partnership with the community to implement a Community Planning Group (CPG) to develop a comprehensive HIV Prevention Plan that best represents the needs of the populations infected with or at risk for HIV.”

History and Background

In 1993, The Centers for Disease Control and Prevention (CDC) issued guidelines for HIV Prevention Community Planning under the Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects. The Guidance document:

- Established the CDC’s requirements for a collaborative process to determine the HIV prevention priorities for the 65 state, territorial, and local health departments that receive HIV prevention funds, based on extensive input from community and government officials.
- Mandated health departments to implement HIV prevention community planning in fiscal year (FY) 1994 in order to qualify for HIV prevention funding for FY 1995 and beyond.
- outlined a process for health departments administering HIV prevention funds, representatives of the communities for whom the services are intended, epidemiologists and behavioral scientists to work together to identify high priority prevention needs which would then serve as the basis for health departments’ HIV prevention allocation decisions.

In 2003, the CDC revised its Guidance document in correlation with a new initiative entitled Advancing HIV Prevention: New Strategies for a Changing Epidemic. Under this new initiative, the focus of HIV Prevention was expanded to include targeting prevention efforts toward persons who are already infected with HIV to help them reduce the risks of transmitting the virus to others. The 2003 Guidance also integrated goals from the CDC’s Healthy People 2010 program as well as the HIV Prevention Strategic Plan Through 2005.

State and Local Community Planning

In February 1994, under the CDC’s mandate, the State of Florida formed a statewide planning body to address prevention community planning as well as other HIV/AIDS early intervention and patient care issues. This body was known as the “Florida HIV/AIDS Community Planning Group” (FCPG). In addition, 14 local community planning partnerships (CPP’s) were assembled across the state.

The local planning partnerships were intended to assist the statewide body in developing its application for prevention funding each year. This is accomplished today by each partnership completing local HIV Prevention Comprehensive Plans that are then integrated to form a single comprehensive plan for the state. The Florida Department of Health has initiated a three-year planning cycle for the local and state comprehensive plans.

In August 2003, the Florida Department of Health requested a workgroup of FCPG members to evaluate the planning process for efficiency and effectiveness. In December 2003, based on recommendations from the workgroup, the FCPG was re-structured to form the Florida Comprehensive Planning Network (FCPN), which was designated as an “umbrella” organization under which three separate planning bodies would operate. The Prevention Planning Group (PPG) of the FCPN meets at least twice each year to coordinate community planning efforts across the state.

In August 2005, the DOH announced that could no longer maintain financial support for the individual local prevention planning partnerships. Funding for local planning was discontinued throughout the State in January 2006. Each regional planning district was given autonomy to determine how HIV Prevention Community Planning will be conducted within their local jurisdiction.

Section 6:
Lead Agency

General Information

The Ryan White Part B Lead Fiscal Agency play an essential role in providing HIV patient care and support services to the HIV/AIDS population. The majority of Florida's Ryan White Lead Agencies are private, non-profit organizations and responsible for administrative, fiscal, reporting and other Part B related duties as specified in the Ryan White Part B contract. All Lead Agencies act as the fiscal conduit and data coordinator for the HIV/AIDS contracted providers in their area. The Health Planning Council of Northeast Florida (HPCNEF) is the Lead Agency for Ryan White funds in Volusia and Flagler Counties.

Role and Responsibilities

Lead Agency roles not only include managing Part B funds for the consortium's planning and administration, but also for the provision of primary care and support services for PLWHA. In Florida, the State designates the responsibilities of the lead agencies and contracts directly with them. A summary of the roles and responsibilities of the Lead Agency include:

- Providing administrative support to the consortium, maintaining consortium files and organizing consortium mailings
- Procurement - develop and implement subcontracts
- Fiscal management – processing invoices and reimbursing subcontractors, submitting financial and program reports to the State.
- Contract Management monitoring contract compliance
- Develop, prepare and submit with the consortia, the Ryan White Part B Comprehensive Plan for Area 12 once every three years and updating annually.
- Ensuring the client satisfaction surveys are conducted and reviewed
- Administering Need Assessments

Section 7: **Definitions**

What is AIDS?

Definitions

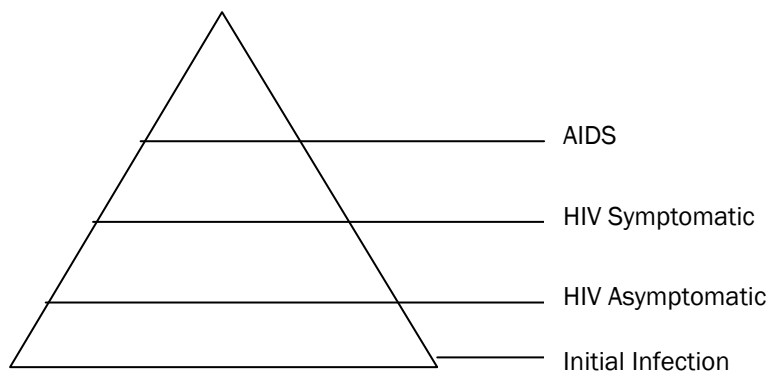
HIV – Human Immunodeficiency Virus – The virus that causes AIDS.

AIDS – Acquired Immune Deficiency Syndrome: – A result of human immunodeficiency virus (HIV) infection. The Centers for Disease Control and Prevention (CDC) defines AIDS as a “positive HIV serum test **and** T-cell count of fewer than 200 per milliliter of blood **or** one or more opportunistic diseases or conditions.” AIDS is the stage of HIV infection in which opportunistic diseases and conditions occur because of suppressed immune system.

The first AIDS cases were reported in the U.S. in June 1981. The earliest documented AIDS case in the world occurred in England in 1959. Most people in the world got infected by having sex with an infected person. Most other cases have been shown to have been caused by direct blood-to-blood contact, usually through the sharing of needles. HIV/AIDS does not discriminate. No one is immune. HIV/AIDS **is not** caused by casual contact with an infected person. HIV has been found in almost every body fluid. However, infection most notably occurs through the exchange of the following body fluids: blood, semen, vaginal secretions and breast milk. HIV may be transmitted through any type of sexual contact (anal, genital or oral). The length of time from infection with HIV until the first life-threatening opportunistic infection can be detected averages about ten years.

Illustration

The following illustration shows how HIV progresses and finally develops into AIDS.



Transmission of HIV

Most often, HIV is transmitted in one of two ways in the United States, by sex and by sharing drug needles. Approximately two thirds of all reported AIDS cases were transmitted sexually. This includes genital, anal or oral sexual contact. About one fourth were transmitted by injecting drug users who shared needles and syringes. Transfusion related cases and HIV contaminated blood products given to hemophiliacs have represented less than 3% of the total of all cases. Nearly all of these cases were in people infected before 1985, when the blood supply was first tested for HIV antibodies. Around 6% of the cases have been categorized as “no identified risk,” whose risk factors were unknown. Other factors of non-sexual transmission include perinatal which is when a mother passes the virus to her unborn child through the placenta and also passing the virus during delivery. HIV has also been found to be passed through breast feeding.

Definitions & Acronyms

ADAP – AIDS Drug Assistance Program is a program authorized and primarily funded under Part B of the CARE Act that is administered by State agencies for providing FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid or Medicare Part D.

AETC – AIDS Education and Training Center: Regional centers providing education and training for primary care professionals and other AIDS-related personnel; authorized under Part F of the CARE Act and administered by HRSA's Division of Training and Technical Assistance.

Administrative or Fiscal Agent – Organization, agent or other entity which assists a grantee in carrying out administrative activities. Not all grantees use a separate administrative or fiscal agent.

AICP – AIDS Insurance Continuation Program, funded through the State of Florida, Dept. of Health program to help pay insurance premiums.

AIDS – Acquired Immune Deficiency Syndrome

AIMS – AIDS Information Management Systems for Patient Care Programs Reporting System

AHCA – Agency for Health Care Administration is the state agency that administers Florida Medicaid.

Anonymous Testing - testing done with no identifying information recorded; only the person tested can obtain the test results.

Area 12: The State of Florida is divided into fifteen areas two of which are divided into two separate planning areas equaling a total of seventeen areas. Area 12 comprises Volusia and Flagler Counties.

ASO – AIDS Service Organization: An organization, which provides medical or support services primarily or exclusively to populations infected with and affected by HIV disease.

CARE Act – The Ryan White HIV/AIDS Treatment Extension Act of 2009 is the Federal legislation enacted to address the health care and service needs of people living with HIV disease and their families in the United States and Territories; enacted in 1990 and reauthorized in 1996 and 2001, and modernized in December 2006 and extended in 2009.

CBO - Community Based Organization. A structured group offering services to a specific group of people in a defined area. These groups may include minority groups, housing for homeless, and AIDS service organizations.

CDC – Centers for Disease Control and Prevention, The Federal agency within the U.S. Department of Health and Human Services that administers HIV/AIDS prevention programs, including the Community Planning process, among other programs; responsible for monitoring and reporting of infectious diseases.

CD4 – One of two protein structures on the surface of a human cell that allows HIV to attach, enter and thus infect a cell. CD4 molecules are present on “CD4 cells” (helper T-lymphocytes), macrophages, and dendritic cells, among others. Normally, CD4 acts as an accessory molecule, forming part of larger structures (such as the T-cell receptor) through which T-cells and other cells signal each other. In particular, it participates in the interaction between helper T-cells and the MHC (Major Histocompatibility Complex) class II molecules on antigen presenting cells.

CD4 Cell Count – The most commonly used surrogate marker for assessing the state of the immune system. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm³. If the count is lower, testing every three months is advised.

CHD – County Health Department

CMS – Children’s Medical Services

CMS – Centers for Medicare & Medicaid Services is the Federal agency within HHS that administers the Medicaid, Medicare, State Child Health Insurance program (SCHIP), and the Health Insurance Portability & Accountability Act (HIPAA).

Co-morbidity – A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

Community Level Interventions – Seek to reduce risk behaviors by changing attitudes, norms, and practices through health communications, prevention marketing, community mobilization/organization, and community events.

Community Mobilization – Programs that attempt to get a community more involved in HIV prevention work; either through recruiting volunteers, organizing support groups, advocacy campaigns or possibly establishing new agencies.

Community Representative – A private citizen: (i.e., not a DOH, state, district or county employee).

Comprehensive Planning – The process of determining the organization and delivery of HIV services; strategy used by a planning body to improve decision making about services and maintain a continuum of care for PLWHA.

Comprehensive HIV Prevention Plan – provides, an overview of all HIV prevention programs and activities occurring in a jurisdiction/area whether they are supported by the CDC or DOH or not. It is to be developed through a participatory planning process.

Confidential Testing - Testing in which test results are linked to persons and recorded in medical files. State laws limit who can have access to the results and under what conditions they can gain access.

Consortium/HIV Care Consortium – A planning entity established by many State grantees under the Care Act plan and an association of health care and support service providers that develops and delivers services for PLWHA.

Cultural Competence – The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

DCF – Department of Children & Families

DOH – Department of Health

DSS – Division of Service Systems – The division within HRSA’s HIV/AIDS Bureau that administers Part A and Part B of the CARE Act.

EIS - Early Intervention Services – Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Part A, B & C, the CARE Act includes outreach, counseling and testing, information and referral services.

Eligibility Rule – The statutory and programmatic authority for the HIV/AIDS Patient Care Program’s eligibility, requirements, process and procedures are based in Chapter 381 Florida Statutes Public Health Code and Chapter 64D-4, Florida Administrative Code.

Epidemic – A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

Epidemiologic Profile – a description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area

Epidemiology - The branch of medical science that studies the incidence, distribution, and control of disease in a population.

Exposure Category – In describing HIV/AIDS cases, same as transmission categories; how an individual may have been exposed to HIV, such as injecting drug use, male-to-male sexual contact, and heterosexual contact.

FCPN - Florida Comprehensive Planning Network

Focus Group - a method of information collection involving a carefully planned discussion among a small group led by a trained moderator.

Grantee – The recipient of CARE Act funds responsible for administering the award

Group Level Interventions – Health communications, health education, and risk reduction interventions for groups, which provide education and support, as well as promote and reinforce safer behaviors.

HAART – Highly Active Antiretroviral Therapy HIV treatment using multiple antiretroviral drugs to reduce viral load to undetectable levels and maintain/increase CD4 levels

HAB – HIV/AIDS Bureau – The bureau within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White CARE Act.

HAPC – HIV/AIDS Program Coordinator

HARS – HIV/AIDS Reporting System

Health Education Risk Reduction (HERR) – Culturally competent HIV prevention education programs and services targeted to persons whose behaviors or personal circumstances place them at high risk of becoming HIV infected or if already infected, of transmitting the virus to others.

HIPAA – Health Information Portability and Accountability Act of 1996 – The Privacy Rule established national standards to protect a person’s confidential information, and to give patients more access to their own medical records.

HIV Disease – The entire spectrum of the natural history of the human immunodeficiency virus, from post infection through the clinical definition of AIDS

HIV/AIDS Dental Reimbursement Program – The program within HRSA’s HIV/AIDS Bureau, Division of Community Based Programs, that assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV-positive patients.

HOPWA – Housing Opportunities for People with AIDS - A program administered by the U.S. Dept. of Housing and Urban Development (HUD) that provides funding to support housing for PLWH and their families.

HRSA - Health Resources and Services Administration – The agency of the U.S. Department of Health and Human Services that administers various primary care programs for the medically underserved, including the Ryan White CARE Act.

HUD – U.S. Department of Housing and Urban Development – The Federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for People with AIDS (HOPWA).

Incidence – The number of new cases of a disease that occur during a specified time period.

Incidence Rate - The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 persons. AIDS incidence rates are often expressed this way.

Individual Level Interventions- provide ongoing health communications, health education and risk reduction counseling to assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior.

Injection Drug User (IDU) – Sometimes known as IVDU or intravenous drug users, injection drug users are anyone who injects drugs into his or her body.

Intervention – An action designed to come between as an influence. HIV prevention interventions for example are actions/programs designed to influence behavior or situations so as to diminish the chance for HIV transmission.

Lead Agency – The agency within a Part B consortium responsible for contract administration; also called a fiscal agent (an incorporated consortium sometimes serves as the lead agency).

MAI – Minority AIDS Initiative – A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color.

Maintenance of Effort – The Part A and Part B requirement to maintain expenditures for HIV-related services/activities at a level equal to the preceding one-year period.

MSM- Men who have sex with other men.

MSM/IDU – Men who report sexual contact with both other men and injection drug use.

Media/Advertising - Traditional advertising strategies such as billboards, bus posters or public service announcements. These would include in-kind media or advertising services as well as those services that are purchased by the prevention provider.

Medicaid Spend-down – A process whereby an individual who meets the Medicaid medical eligibility criteria, but has income that exceeds the financial eligibility ceiling, may “spend down” to eligibility level.

Met and Unmet Needs - A met need is a requirement for HIV prevention services within a specific target population that is currently being addressed through existing HIV prevention resources that are available to, appropriate for, and accessible to that population (as determined through the resource inventory and assessment of prevention needs). For example, a project area with an organization for African American gay, bisexual, lesbian and transgendered individuals may meet the HIV/AIDS education needs of African American men who have sex with men by its outreach, public information and group counseling efforts.

An *unmet* need is a requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services or activities, either because no services are available or because available services are either inappropriate for, or inaccessible to, the target population.

Mortality Rate - The rapidity with which persons within a given population die from a particular disease.

NIR – No Identified Risk

NMAC - National Minority AIDS Council

Needs Assessment – A systematic process to determine the service needs of a defined population; a definition of the extent of the need, available services, and gaps or unmet needs by population and geographic area.

PAC – Project AIDS Care

Part F – The part of the CARE Act that includes the AETC Program and the HIV/AIDS Dental Reimbursement Program.

PCHAP – Partnership for Comprehensive HIV/AIDS Planning.

PCRS – Partner Counseling and Referral Service

PIR – Parity, Inclusion, Representation - **Parity** is when all members of the community planning group have the opportunity to acquire the skills and knowledge to participate in the planning process and have equal voice in voting and decision making. **Inclusion** is the assurance that the views, perspectives, and needs of all affected communities are included and involved in a meaningful manner in the community planning process. **Representation** is the assurance that those who are representing a specific community truly reflect that community's values, norms, and behaviors

Patient Care – All care and services for persons with HIV disease or AIDS

Peer Education - Peer education is HIV/AIDS education provided by trained, self-identified members of the target population to groups of peers. Peer educators usually serve as role models, demonstrating to peers behaviors that promote risk reduction.

Peer Support Counseling – Individual or group support counseling sessions facilitated by a trained, self-identified member of the target group, population, i.e., a peer outreach educator.

PHI – Protected Health Information: – Permission to use or disclose PHI for treatment, payment & healthcare operations. PHI cannot be used or disclosed for purposes other than treatment, payment or health care operations without authorization from the patient.

PHS – Public Health Service

PLWHA – Person (people) Living with HIV/AIDS.

Prevalence – The total number of persons with a specific disease or condition at a given time.

Prevalence Rate – The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

Prevention - All primary and secondary activities dealing with the prevention of HIV disease or AIDS. Primary activities include activities such as street outreach programs, prevention case management, etc. Secondary activities include: HIV counseling and testing, AIDS surveillance and capacity building for CBO's, local governments, etc.

Prevention Case Management (PCM) – A one-on-one client service designed to assist both uninfected persons and those living with HIV. PCM provides intensive, individualized support and prevention counseling to assist persons to remain seronegative or to reduce the risk for HIV transmission to others by those who are seropositive. PCM provides intensive, on-going, individualized prevention counseling.

Primary Prevention – Efforts to reach persons at high or increased risk of becoming HIV-infected, or if already infected, of transmitting the virus to others, with the goal of reducing the risk of these events occurring.

Priority Setting – The process used by a planning group to ensure consistency with locally identified needs, and to address how best to meet each priority.

Process Evaluation- Process evaluation provides a descriptive assessment of a programs actual operation and the level of effort taken to reach desired results, that is, what was done by whom, and how, when, and where. A process evaluation does not examine the effectiveness of a program.

RMAC - Regional Minority Aids Coordinator

RFP – Request for Proposals.

Referral – A process by which an individual or client who has a need is connected with a provider who can serve that need (usually a different agency).

RSR - Ryan White HIV/AIDS Program Services Report is the annual report required to collect aggregate data all CARE Act programs.

SAMHSA – Substance Abuse and Mental Health Services Administration: – Federal agency within HHS that administers programs in substance abuse and mental health.

SCSN – Statewide Coordinated Statement of Need – A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination. The SCSN process is convened by the Part B Grantee, with equal responsibility and input by all programs.

Secondary Prevention – As related to HIV prevention, the aim of secondary prevention is to prevent a person living with HIV from becoming ill or dying as a result of HIV, opportunistic infections, or AIDS through a variety of strategies, activities, interventions, and services.

Sexually Transmitted Disease (STD) - A disease transmitted only or chiefly by sexual contact with a person infected with the disease.

Small Group Support – a casual, discussion or support group-type setting for the sharing of information between group members, can be one-time or multi-session.

SPNS – Special Projects of National Significance – A health services demonstration, research and evaluation program funded under the CARE Act to identify innovative models of HIV care. SPNS projects are awarded competitively.

Strategy - The art of planning, directing, maneuvering resources/interventions in such a way as to give HIV prevention providers an advantage in the fight against HIV/AIDS.

Surveillance – Ongoing monitoring of all aspects of the spread of disease that are important to effective control. The main purpose of surveillance is to detect changes in trend or distribution of disease.

Target Population - Also known as Priority Population, the group, community, or population that a prevention provider defines as that for which they provide services. The group can be specified by ethnicity, behavioral risk, sexual orientation/identity, age, or any co-factors.

Technical Assistance - Aid, support, or help provided to individuals or organizations on a particular area or specific skill. Technical assistance can be provided, for example to HIV prevention providers who are interested in learning more about program evaluation.

Sources:

Ryan White HIV/AIDS Treatment Extension Act of 2009

Guidelines for Health Education and Risk Reduction Activities; Centers for Disease Control and Prevention 1996.

Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects, issued by the Centers for Disease Control and Prevention in 1993.

Ryan White CARE Act Title II Manual, issued by U.S. Department of Health & Human Services, HRSA (Health Resources & Services Administration).

Care /Prevention Collaborative Planning; HRSA AIDS Programs Title I and Title II; Planning Bodies and CDC Prevention Community Planning Groups, issued by the U.S. Department of Health & Human Services, HRSA (Health Resources & Services Administration).

PCHAP

PARTNERSHIP FOR
COMPREHENSIVE
HIV/AIDS PLANNING

Appendix:

BYLAWS of the Partnership for Comprehensive HIV/AIDS Planning (PCHAP)

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ARTICLE ONE – Name and Headquarters

The name of the organization will be known as The Partnership for Comprehensive HIV/AIDS Planning, herein referred to as “the Planning Group” for the purpose of these bylaws. The Administrative office will be located at the Lead Agency in the designated service area for the purposes of maintenance of records and coordination of activities or at some other location as may be determined from time to time by the Planning Group.

ARTICLE TWO – Mission and Vision

Section 1: Mission Statement

The mission of the Planning Group is to plan a comprehensive array of HIV/AIDS services spanning from prevention to early intervention and patient care through active, open, and inclusive community planning processes that emphasize delivery of quality and effective services to all clients and communities affected by HIV/AIDS within the boundaries of Volusia and Flagler Counties.

Section 2: Vision Statement

The vision of the Planning Group is: “Public and private individuals and agencies working cooperatively in an atmosphere of mutual trust, dignity and respect, to plan a seamless continuum of accessible, high quality services to all people of Area 12 affected by HIV/AIDS across the lifespan.”

ARTICLE THREE – Roles and Objectives

The role of the Planning Group in the planning process is to:

1. Participate in the development, implementation, evaluation and updating of the Local Comprehensive Plan for people with HIV/AIDS.
2. Identify service needs and assess community resources.
3. Prioritize HIV/AIDS services needs for all populations
4. Provide recommendations regarding the percent allocation of Ryan White CARE Act funds to prioritized service categories.
5. Promote greater cooperation among all agencies delivering HIV-related health and human services.

ARTICLE FOUR – Membership and Responsibilities

Section 1: Composition of Members– The Planning Group membership should include organizations, public and private, with experience in HIV/AIDS service delivery and populations and subpopulations of persons living with HIV/AIDS (PLWHA) and/or persons affected by HIV/AIDS,. In order to ensure diverse experience and input, members should be representative of, but not limited to, the types of organizations and expertise recommended in the most current guidance from both the Health Resources Service Administration (HRSA) and the Center for Disease Control (CDC). The Planning Group membership will consist of a minimum of 25% PLWHA or persons affected by HIV/AIDS.

Section 2: Eligibility - The Planning Group shall be open to any individual residing or working in the Planning Group’s geographic service area who demonstrates affirmative interest and concern to improve the health of people living with HIV/AIDS. Only those individuals who have completed the orientation process and attended at least two of the last three Planning Group meetings will be eligible to vote. No more than two paid staff members from any one organization who are not self identified PLWHA’s and not more than six (6) PLWHA’s from any one organization, may be voting members of the Planning Group.

Section 3: Attendance & Voting Privileges – Individuals who have completed the PCHAP membership application, PCHAP Orientation, and attended two of the last three full Planning Group meetings may vote. Any person who is unable to physically participate in activities may receive special exemption to participate via meeting technology. Members must also select one Primary Standing Committee and must attend all regularly and duly called meetings of their Primary Standing Committee to maintain voting privileges.

Section 4: Recruitment of Members – All Planning Group members will be responsible to assist in the recruitment of individuals from all represented geographic areas, infected and affected population groups and various fields of expertise, including people who have an interest in the health of persons living with HIV/AIDS.

Section 5: Duties – Active Voting Members agree to participate in the planning, implementation and evaluation of a comprehensive service plan for people living with HIV/AIDS and participate actively on at least one Primary Standing Committee.

Section 6: Membership Terms and Resignation – Active Voting Membership terms shall be perpetual unless otherwise provided by these bylaws. Any member may at any time resign as a member by submitting a written resignation to the Chair to be effective upon receipt.

Section 7: Removal of Members – Any member may be removed, with cause, by a majority vote (75%) of the Planning Group.

Section 8: Conflict of Interest – In the conduct of all business, the Planning Group will act in accordance with all local and state laws pertaining to conflicts of interest. In order to safeguard the Planning Group recommendations to the Department of Health from potential conflict of interest, each member will disclose any and all professional and/or personal affiliations with agencies that may pursue funding from the Department of Health, from the Department of Health's agents, or from other agents as might be affected by the recommendations of the Planning Group.

Section 8a: Each member will complete a Disclosure Statement form annually indicating their willingness to leave behind special interest of their agency during Planning Group deliberations and agree to act only on behalf of the broadly affected HIV community. All completed Disclosure Statement forms will be kept on file by the Lead Agency. A review of the conflict of interest policy and procedures will be conducted during at least one meeting of the Planning Group in each calendar year.

Section 8b: A Planning Group Voting Member who also serves as a director, trustee, board member, or a salaried employee or otherwise materially benefits from association with any agency, which may seek funds from the Lead Agency, is deemed to have an "interest" in said agency or agencies regardless of HIV status.

Section 8c: All Planning Group members with a conflict of interest shall abstain from voting on issues that relate to the source of conflict. A member may be removed from the Planning Group and all Planning Group Committees when it is determined that the members knowingly attempted to influence Planning Group in an area of conflict of interest.

Section 8d. The Planning Group Chair has the prerogative of calling for a vote to determine whether a member will have voting privileges on any issue(s) in question.

ARTICLE FIVE – Governance Of Meetings

The Voting Membership will elect a Chair and Vice-Chair. The Chair shall preside over full meetings of the Planning Group. In the absence of the Chair, the Vice Chair shall preside over full meetings.

All business that may come before the Planning Group will be addressed with an open, consensus-building decision-making process. Should consensus-building activities fail to facilitate the effective conduct of any business at hand, the Chair, at their discretion, may elect to conduct a meeting or any part thereof, according to the procedures established in the current edition Robert's Rules of Order, Newly Revised

Section 1: Schedule of Meetings – The Planning Group voting membership meetings will meet at least once every two months to conduct regular business. Should the business to be addressed by the Planning Group be less than or more than usual, the Chair may postpone, cancel or schedule meetings as needed.

Section 2: Meeting Venues – All Planning Group meetings are open to the public. The Planning Group will meet in locations and at times that are convenient to the general public whenever possible.

Section 3: Emergency Meetings – Meetings to address urgent business may be called as needed by the Chair. At the discretion of the Chair, urgent business may be addressed through:

- a) Audio or audio/video conferences with available Planning Group members, or
- b) Through a diligent polling of all voting members by the Chair or their designees.

All such urgent business and the process by which decisions are reached must be fully and completely documented and submitted to the Planning Group for review at the next regularly scheduled meeting.

Section 4: Meeting Notices – Notices of regularly scheduled meetings will be publicly posted at least 10 days before a meeting is to be held. Notification of meetings and other information pertaining to the Planning Group will be mailed or emailed directly to the Planning Group members no later than two weeks prior to the meeting by the Lead Agency.

Section 5: Decision Making – The decisions of the Planning Group and Committees will be based primarily on consensus building that takes place during duly called meetings at which a quorum (33%) of all current voting members is present. Should the voting members fail to reach a consensus within a reasonable amount of time as determined by the Chair, the Chair may, at their discretion, invoke Robert's Rules of Order, Newly Revised, and call for a vote on the question to be determined. Any voting member may call for a vote on any specific issue by putting forth a motion. A simple majority of votes cast on any such issue shall be sufficient to decide the issue. The Chair shall abstain from voting in such instances, unless their vote would either cause or break a tie, in which case the Chair may use their discretion in voting.

ARTICLE SIX – Committees

Section 1: Primary Standing Committees - Members must select a Primary Standing Committee on which to participate. The Primary Standing Committees are Needs & Resources and Standards & Quality. The Planning Group *recommends* that at least 25% of all Committees be people living with HIV/AIDS or affected by HIV/AIDS. Committees will meet as determined by the needs of the Planning Group.

The decisions of each committee will be based primarily on consensus building that takes place during duly called committee meetings at which a quorum (33%) of all current voting members is present. Should the voting members fail to reach a consensus within a reasonable amount of time as determined by the Committee Chair, the Chair may invoke Robert's Rules of Order, Newly Revised and call for a vote on the question to be determined. Any committee voting member may call for a vote on any specific issue by putting forth a motion. A simple majority of votes cast on any such issue shall be sufficient to decide the issue. The Committee Chair shall abstain from voting in such instances, unless the Chair's vote would either cause or break a tie, in which case the Chair may use their discretion in voting.

Section 1a: 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.

Section 1b: 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

Section 2: Secondary Committees - The Secondary Committees are Steering, Priorities & Allocations, Nominating and Ad-hoc. The Planning Group *recommends* that at least 25% of all Committees be people living with HIV/AIDS or affected by HIV/AIDS.

Section 2a: Steering Committee – The Chair of the Planning Group will serve as the Chair of the Steering Committee. The Steering Committee will consist of the Officers of the Planning Group and the Chairpersons of each committee. The Steering Committee will oversee the overall community planning process, maintain the bylaws, recruit new members, review conflict of interest claims and provide input to the Lead Agency as needed.

The Committee will review and update bylaws annually or as needed. The Committee will accept written requests for proposed bylaw changes from any active Planning Group member, review each request, draft changes, if any, and present the draft recommendations to the Planning Group for a final vote.

The Committee will also review and update annually, or as needed, the conflict of interest policy and distribute to all Planning Group members. The Committee will review potential conflicts of interest according to established policies and procedures at the request of any active Planning Group member.

Vacant Committee Chair positions will be selected and appointed by the Steering Committee in accordance with the by-laws. Nominating Committee Chair will serve as ex-officio on Steering Committee. In the event a vice-chair resigns or is no longer able to fulfill their duties, the Steering Committee will convene within 30 days or prior to the next Planning Group meeting whichever comes first, and a replacement will be selected from within its ranks.

Section 2b: Priorities and Allocations Committee – The Priorities and Allocations Committee will conduct priority setting and allocation tasks as required by the Florida Comprehensive Planning Network for the Bureau of HIV/AIDS for the Ryan White Part B funding, as well as by other funding sources. At least 25% of the Priorities and Allocations Committee members **must** be people living with HIV/AIDS. In determining priorities and allocations, the committee will rely on the work produced by the Needs and Resources Committee, which will have direct input from consumers, local AIDS services organizations and the Health Department. Planning Group Bylaws will guide Conflict of Interest, all committee members will review their Conflict of Interest statements to insure that they are current and all committee members will complete Conflict of Interest forms. All committee members should place the needs of the entire HIV population above any specific concerns. No more than one member from any agency may vote on the committee, these agency representatives will determine and notify the chair which member will vote. Committee members who are also Ryan White Part B service providers may not vote on their own service categories and are expected to treat all categories fairly. The chair will enforce the conflict of interest policy with the assistance of other committee members. Any committee member who believes a conflict of interest exists is expected to raise his/her concern immediately so that it may be resolved. Clients/consumers do not incur a conflict of interest merely by receiving services from an agency, but **DO** have a conflict if they are employed by, or a member of the Board of Directors of an agency. Committee members must be present to vote. Active Committee members are those who have attended two of the last three most recent meetings, including the current meeting. Recommendations to the full Planning Group from the Priorities and Allocations Committee will be subject to a strict “up or down” vote (approval or rejection) and may not be amended or modified by the full Planning Group and if rejected will be sent back to the committee.

Section 2c: Nominating Committee – The Nominating Committee is comprised of no more than five members to identify and present a slate of officer nominees to the Planning Group. The Nominating Committee will prepare a slate of officers to nominate for each duly held election by seeking qualified applicants from among current active voting members in good standing. Chair of the Nominating Committee shall be an active voting member selected by voting members during the Planning Group meeting and will serve as ex-officio on the Steering committee. The Nominating Committee convenes in October and prepares a slate of officers to present to the Planning Group in February.

Section 2d: Ad-Hoc Committees – The Chair may appoint Ad-Hoc committees as he or she deems necessary to address issues that do not logically fall under another committee, or issues that require immediate attention and cannot be addressed by another committee. In appointing such Ad-Hoc committees, the Chair will set a specific task to be completed with an initial timeline for the committee to report back to the Planning Group. Ad-Hoc committees tend to be short in their duration. During the time an Ad-Hoc committee is constituted, the Chair of that committee shall serve on the Steering Committee.

ARTICLE SEVEN – Officers

Section 1: Elections – The Planning Group shall elect a Chair and Vice-Chair from the membership at an annual meeting with a quorum present. The officers shall be elected by a majority of the votes cast. The Nominating Committee will prepare and publicize a potential slate of officers at least thirty days in advance of the election. Nominations for all officers will also be accepted from the floor at least thirty days prior to the Annual Meeting. The officers will be elected for a one-year term. No officer shall hold the same office for more than two consecutive terms. The officers will guide the Planning Group in achieving its mission and goals.

Minimum qualifications for the officers include being a resident of Volusia or Flagler counties and participation as a member in good standing of the Planning Group for at least one year.

Section 2: Duties of Officers

A. Chair: The Chair’s duties and responsibilities will be to:

- Represent the Planning Group to the State of Florida, the Health Department and to other organizations and interested parties
- Preside at the monthly meetings of the Planning Group meetings and the Steering Committee
- Be an ex-officio member of all committees
- Have the authority to break a tie or cause a tie in votes at the Planning Group and Steering Committee meetings
- Delegate responsibilities, as appropriate, to the Vice Chair and other members of the Planning Group
- The Chair will set the agenda for Planning Group

B. Vice-Chair: The Vice-Chair shall serve in the absence or disability of the Chair. This designee shall perform all powers and duties of the office. In the event the office of the Chair of the Planning Group becomes vacant, the Vice-Chair shall serve the un-expired term but this shall not be considered a full term.

C. Removal of officers: The Planning Group may, at its discretion, remove any officer upon a 75% (three-fourths) of the votes cast at a duly called meeting where a quorum is present.

ARTICLE EIGHT – Florida HIV/AIDS Comprehensive Planning Network (FCPN) Representation

The Planning Group will be represented at the Florida HIV/AIDS Comprehensive Planning Network (FCPN)

1. One representative and alternate will each be a Planning Group voting member with interest/expertise in HIV Patient Care. A letter of recommendation for this member and alternate will be prepared by the Chair of Planning Group, based on their nomination by Planning Group.
2. One representative and alternate will each be a Planning Group voting member with interest/expertise in HIV Prevention. A letter of recommendation for this member and alternate will be prepared by the Chair of Planning Group, based on their nomination by Planning Group.
3. Planning Group may also nominate “At Large” representative(s) who are Planning Group voting members with interest/expertise in other areas as defined in the FCPN guidance. A letter of recommendation for this (these) member(s) will be prepared by the Chair of Planning Group, based on their nomination by Planning Group

Each of the FCPN representatives and alternates that are recommended by Planning Group and accepted by the Bureau of HIV/AIDS as a representative or an alternate must be a voting member in good standing of Planning Group throughout their FCPN term, and report on the activities of FCPN at the regular Planning Group meetings.

ARTICLE NINE – Books and Records

The Lead Agency will keep minutes of all proceedings of the Planning Group and other books and records as may be required for the proper conduct of its business and affairs. Voting records will be maintained at the Administrative office and be open to the public for review.

ARTICLE TEN – Amendments

Written notice of proposed bylaws changes will be mailed or delivered to each member at least 10 days prior to the date of the meeting in which a vote will be taken.

Amendments require a two-thirds (2/3) majority vote of the voting members present at a duly called meeting with a quorum.

ARTICLE ELEVEN – Dissolution

The Planning Group may be dissolved by its voting membership upon acceptance of a resolution of dissolution by a two-thirds (2/3) majority vote of the voting members present at a duly called meeting with a quorum.

ATTACHMENTS

1. Code of Conduct
2. Job Descriptions
3. Grievance Procedure
4. Grievance Form

PCHAP

PARTNERSHIP FOR
COMPREHENSIVE
HIV/AIDS PLANNING

Code of Conduct

- Behave in a manner that reflects their responsibility to represent the group
- Hold in confidence information presented in confidence
- Address comments to the Chair
- Declare when an issue being discussed may benefit themselves, their employer or a family member/significant other. Issues that will potentially benefit all PLWHA in the service area do not have to be declared by a member who is a PLWHA or a member who has a family member/significant other who is a PLWHA, provided there is no additional potential benefit to the member or family member/significant other than would benefit any other PLWHA in the service area who is not a member of the group
- Accept and support the decisions made by the group according to the prescribed method(s) of decision-making
- Take positive responsibility for helping to prevent and resolve conflicts within the group.
- All members will be given a chance to speak once on each issue before recognizing a member who has already spoken on the issue. This does not apply to Points of Order or Points of Information (questions) or the member of whom the Chair requests an answer.
- Take responsibility for following this Code of Conduct as well as speaking out to ensure other members abide by this Code of Conduct
- Agree that a civil atmosphere should prevail at each meeting
- Not interrupt people when they are speaking
- Show respect to other members of the community group
- Identify yourself prior to speaking so that the tape can pick up who is speaking
- Ask to be identified by the Chairperson prior to speaking
- Avoid side conversations with other members during the meeting
- Be on time for meetings
- Speak for yourself and do not claim to speak for others
- Be polite. It's acceptable to disagree, but do so respectfully
- Agree that insults and accusations are unacceptable
- Turn all pagers and cell phones off or to the "vibrate" position
- Leave personal agendas/attitudes/hidden agenda/ego at the door
- Be respectful of cultural differences
- Observe confidentiality within established policies
- Be open to listening to and learning from other's viewpoints
- Observe conflict of interest policies and declare when an issue being discussed may benefit you, your agency, or a family member

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HIV/AIDS PLANNING

PCHAP Job Descriptions

Position Description

Job Title: Planning Group Member

Reports To: Planning Group

Duties & Responsibilities:

- Attend regular meetings and actively participate on at least one committee
 - Read the minutes from the previous meeting and meeting packet material prior to each meeting
 - Bring all materials sent to you by the Lead Agency to the meeting
 - Work with others to develop a comprehensive array of HIV/AIDS services, including prevention, early intervention, and patient care
 - Serve as a knowledgeable person with information about HIV/AIDS services: not as an “agency representative” (Leave “turf issues” at the door)
 - Declare all potential conflicts of interest
 - Recruit members to the Planning Group
-

Position Description

Job Title: Chair

Reports to: Steering Committee and the Planning Group

Minimum qualifications: Ability to lead; administrative capability; ability to communicate in both written and verbal formats; willingness to serve and must be a voting member in good standing.

Duties & Responsibilities:

- Facilitate meeting of the Planning Group and Steering Committee
 - Serve as Ex-Officio member of all other committees
 - Foster an environment of collaboration and cooperation
 - Represent the Planning Group to other organizations and institutions
 - Guide the Planning Group through patient care planning processes
 - Work with the Lead Agency to coordinate the delivery of all required documents
-

Position Description

Job Title: Vice Chair

Reports to: Chair, Steering Committee and Planning Group

Minimum Qualifications: Ability to lead, administrative capability, ability to communicate in both written and verbal formats, willingness to serve, and must be a voting member in good standing.

Duties & Responsibilities:

- Facilitate meeting of the Planning Group and Steering Committee in the absence of the Chair
- Serve as Ex-Officio member of all other committees, attending as many as practical
- Foster an environment of collaboration and cooperation
- Represent the Planning Group to other organizations and institutions
- Assist the Chair in guiding the Planning Group through prevention, early intervention, and patient care planning processes
- Assist the Chair in coordinating with the Lead Agency in the delivery of all required documents in a timely manner
- Assume the position of Chair in the event of resignation or removal of the Chair

Position Description

Job Title: Committee Chairperson

Minimum qualifications: Knowledge of, or interest in, subject of the committee, willingness to serve, ability to facilitate group work, and must be a voting member in good standing of the Planning Group.

Duties & Responsibilities:

- Facilitate regular meetings of members
 - Assure that the committee completes assigned tasks/outcomes
 - Coordinate activities with other committees when necessary
 - Participate in regular Planning Group meetings and provide a narrative report on the committee's progress when requested to do so
 - Participate as active members of the Steering Committee
-

Position Description

Job Title: Nominating Committee Member

Reports to: Nominating Committee Chair & PCHAP

Minimum Qualifications: Nominating Committee members are comprised of active member of the Partnership for Comprehensive HIV/AIDS Planning and are committed to participating impartially to present a slate of officers to the Partnership.

Duties & Responsibilities:

- Convene a minimum of two times annually
- Determine eligibility of members based upon the by-laws
- Accept nominations from the planning partnership
- Confirm acceptance of the nominees
- Present the slate of candidates to the Planning Partnership for a vote

PCHAP

PARTNERSHIP FOR
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HIV/AIDS PLANNING

Grievance Resolution Process Instructions

Grievance Definition:

- ❖ Member grievances should be confined to the consortium's areas of responsibility.
- ❖ Grievances about service providers' performance, clients' complaints, problems with state or local health departments and other matters outside the auspices of the consortium should be pursued elsewhere.
- ❖ Informal methods to resolve differences should be explored prior to initiating a formal complaint.

STEP 1:

The Grievant is to present the grievance in writing, using the grievance form, to the PCHAP Chairperson, addressed to the Health Planning Council, immediately upon becoming aware of the act or condition that is the basis for the grievance, but no later than 30 days.

STEP 2:

The PCHAP Chairperson will respond in writing to the Grievant within seven working days from the date of receipt by the lead agency. The PCHAP Chairperson's reply will state the actions to be taken to resolve the grievance, or outline in detail the reasons why the PCHAP Chairperson is unable to resolve the grievance to the Grievant's satisfaction.

STEP 3:

PART A: If the grievance is not resolved in Step Two, the Grievant may, within seven working days from the date of the PCHAP Chairperson's reply, request Steering Committee review by completing Step Three of the grievance form, and returning the original grievance, and all the responses to the Steering Committee Chairperson addressed to the Health Planning Council.

PART B: The Steering Chairperson will schedule a meeting of the Steering Committee at the earliest time, within 10 working days, to review the grievance. The Steering Committee will render a written response within 3 working days of the called meeting. The Steering Committee Chairperson will forward their response to the Steering Committee.

PART C: The Steering Committee may, at their discretion, request an Ad-hoc committee be formed in circumstances where they feel further review is necessary. The Ad-hoc Committee would then complete this step in lieu of the Steering Committee.

The Steering Committee or Ad-hoc Committee's response is final and not subject to further review.

REPORTING

Copies of the Grievance form will be distributed as appropriate during the resolution process to Grievant, PCHAP Chairpersons, the Steering Committee members and the lead agency. Original copies will be kept by the lead agency and are the sole property of PCHAP.

Health Planning Council of Northeast Florida, Inc.
101 S. Palmetto Av., Suite 5
Daytona Beach, FL 32114

Grievance Form

Step 1 - PCHAP GRIEVANCE

GRIEVANT INFORMATION: (To be completed by Grievant)

Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

GRIEVANCE: (To be completed by Grievant)

INSTRUCTIONS: The Grievant is to present the grievance in writing, using the grievance form, to the PCHAP Chairperson, addressed to the Health Planning Council, immediately upon becoming aware of the act or condition that is the basis for the grievance, but no later than 30 days.

My grievance is as follows:

My proposed solution is as follows:

Grievant's Signature

Date

Health Planning Council of Northeast Florida, Inc.
101 S. Palmetto Av., Suite 5
Daytona Beach, FL 32114
Fax: 386-323-2048

Copies of the Grievance form will be distributed as appropriate during the resolution process to Grievant, PCHAP Chairperson, the Steering Committee members and the Health Planning Council. Original copies will be kept by the Health Planning Council and are the sole property of PCHAP.

STEP 2 – PCHAP Chairperson Reply (To be completed by the PCHAP Chairperson)

INSTRUCTIONS: The PCHAP Chairperson will respond in writing to the Grievant within seven working days from the date of receipt by the lead agency. The PCHAP Chairperson’s reply will state the actions to be taken to resolve the grievance, or outline in detail the reasons why the PCHAP Chairperson is unable to resolve the grievance to the Grievant’s satisfaction.

PCHAP Chairperson’s reply to grievance, stating the action(s) to be taken to resolve the grievance or outlining why the grievance cannot be satisfied:

Signed: _____ Date: _____
(If more space is needed, use additional sheets and attach)

Copies of the Grievance form will be distributed as appropriate during the resolution process to Grievant, PCHAP Chairperson, the Steering Committee members and the Health Planning Council. Original copies will be kept by the Health Planning Council and are the sole property of PCHAP.

STEP 3 – PART A - Request for Steering Committee Review (To be completed by Grievant)

INSTRUCTIONS: If the grievance is not resolved in Step One, the Grievant may, within seven working days from the date of the PCHAP Chairperson’s reply, request Steering Committee review by completing section two of the grievance form, and returning the original grievance and all the responses to the Steering Committee Chairperson addressed to the Health Planning Council.

I have reviewed the PCHAP Chairperson’s reply to my grievance and the grievance has not been resolved to my satisfaction. I request a review by the Steering Committee.

Grievant’s Signature

Date

Grievant must attach original grievance and PCHAP Chairperson’s reply.

STEP 3 – PART B – Steering Committee Review Meeting Scheduled

INSTRUCTIONS: The Steering Chairperson will schedule a meeting of the Steering Committee at the earliest time, within 10 working days, to review the grievance. The Steering Committee will render a written response within 3 working days of the called meeting. The Steering Committee Chairperson will forward their response to the Steering Committee.

The Steering Committee may, at their discretion, request an Ad-hoc committee be formed in circumstances where they feel further review is necessary. The Ad-hoc Committee would then complete this step in lieu of the Steering Committee.

Steering Committee’s reply to grievance, stating the action(s) to be taken to resolve the grievance or outlining why the grievance cannot be satisfied:

Signed: _____
(If more space is needed, use additional sheets and attach)

Date: _____

**Health Planning Council of Northeast Florida, Inc.
101 S. Palmetto Av., Suite 5
Daytona Beach, FL 32114
Fax: 386-323-2048**

STEP 3 – PART C – Steering or Ad-Hoc Committee Final Reply

NOTE: The Steering or Ad-Hoc Committee’s response is final and not subject to further review.

Steering or Ad-Hoc Committee’s Final reply to the grievance stating the action(s) to be taken to resolve the grievance:

Signed: _____ Date: _____
(If more space is needed, use additional sheets and attach)

Copies of the Grievance form will be distributed as appropriate during the resolution process to Grievant, PCHAP Chairperson, the Steering and Ad-Hoc Committee members and the Health Planning Council. Original copies will be kept by the Health Planning Council and are the sole property of PCHAP.

**Health Planning Council of Northeast Florida, Inc.
101 S. Palmetto Av., Suite 5
Daytona Beach, FL 32114
Fax: 386-323-2048**