



## Committee and Subcommittee Membership Application

This is the membership application for the committees and subcommittees of the Miami-Dade HIV/AIDS Partnership, Miami-Dade County's Ryan White Program Planning Council.

**Our vision is to eliminate barriers and disparities, improve health outcomes, and create a healthier, empowered Miami-Dade County for all people living with, impacted by, or vulnerable to HIV.** If you share this vision and have a reputation for integrity, community service, and a demonstrated interest in the field of HIV, you are invited to join!

Your commitment for membership includes:

- Monthly meeting preparation, attendance, and participation.
- Completion of Partnership and/or Miami-Dade County training and annual filing requirements.

### 1. Are you registered to vote in Miami-Dade County?

Yes.  No.  I'm not sure. *Committee and Subcommittee applicants **must be registered to vote** in Miami-Dade County. Please confirm or update your voter status before completing this application.*

### 2. Contact Information

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email: \_\_\_\_\_

*Your email will be added to the Partnership listserv and will be used for regular Partnership correspondence.*

Home Address: \_\_\_\_\_

Home or Cell Phone: \_\_\_\_\_ May we text this phone?  Yes  No

Employer (if applicable): \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone Number: \_\_\_\_\_ May we text this phone?  Yes  No

Are you an officer, employee, representative, or consultant to any Ryan White Program Part A funded service provider?  Yes  No  I'm not sure

### 3. Demographic Information

Sex:  Male  Female

Language(s) I speak:  English  Spanish  Haitian Creole  Other (please specify) \_\_\_\_\_

Race/Ethnicity:  White/Non-Hispanic  Black/Non-Hispanic  Hispanic  Asian/Pacific Islander  
 American Indian/Alaska Native  Other (please specify) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

*Your initials here*

I understand that Partnership Staff will use this information to confirm my voter information from the website <https://registration.dos.fl.gov/en/CheckVoterStatus/Index>.

### 4. Committees and Subcommittees of Interest Check all that apply.

- Care and Treatment Committee** *Service guidelines, Annual Needs Assessment, funding allocations.*
- Community Coalition Roundtable** *Member recruitment and community engagement.*
- Housing Committee** *HOPWA housing and related programs.*
- Medical Care Subcommittee** *Medical standards of care and HIV medications. Seat: \_\_\_\_\_ (e.g, MCM,MD)*
- Prevention Committee/Joint Integrated Plan Review Team** *HIV/STI testing, prevention activities, integrated planning.*
- Strategic Planning/Joint Integrated Plan Review Team** *Program assessment, annual reporting, integrated planning.*

## 5. Disclosure of Personal Health Information Authorization

*This authorization shall become valid immediately and shall remain in effect until revoked.*

Meaningful involvement of people with HIV/AIDS is a cornerstone of Partnership and committee membership.

- ▶ I am applying for membership as a person with HIV.  Yes  No
- I prefer not to disclose my HIV status.** *I understand that I will be considered for membership in other membership categories, provided there is an open seat, and I meet the qualifications for that seat.*
- ▶ I, (print your full name) \_\_\_\_\_, understand that if I wish to be considered for membership as a person with HIV it is necessary to identify my HIV status. By signing this authorization, I willingly disclose my HIV status.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

<i>Your initials here</i>	I understand that this information will become public record and <b>may</b> be discussed in open, public meetings. The Florida Government in the Sunshine Law requires open discussion in a public forum. In addition, I further understand that by signing this release, I waive any exemptions of the information concerning my HIV status pursuant to Chapter 119.07 of the Florida Statutes. My status will be released to anyone who requests a copy of this document.
<i>Your initials here</i>	I further understand that I may revoke this authorization to disclose my HIV status, in writing, prior to my application being considered at the next committee or subcommittee meeting. However, I understand that the information may have already been disclosed on the basis of this authorization.
<i>Your initials here</i>	I authorize the release and exchange of information about my HIV status among and between the Miami-Dade County Office of Management and Budget-Grants Coordination, the Office of the Mayor of Miami-Dade County, the Miami-Dade County Office of the Inspector General, the Miami-Dade HIV/AIDS Partnership, the United States Office of Inspector General, the United States Department of Health and Human Services, and Behavioral Science Research Corporation.

## Cancellation Of Disclosure Authorization

*I wish to cancel this Disclosure of Personal Health Information Authorization. I understand that I am entitled to a copy of this canceled Authorization.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## 6. Signature and Next Steps

Bring your completed application to a meeting or send by:

- Mail: Behavioral Science Research Corporation (BSR), Attn: Staff Support, 2121 Ponce de Leon Boulevard, Suite 240, Coral Gables, FL 33134;
- Email: [mdcpartnership@behavioralscience.com](mailto:mdcpartnership@behavioralscience.com); or
- Fax: (305) 448-3325.

Please contact Partnership staff at (305) 445-1076 or [mdcpartnership@behavioralscience.com](mailto:mdcpartnership@behavioralscience.com), if you need assistance. Upon receipt of your application, BSR staff and/or a Community Coalition Roundtable mentoring member will contact you to review next steps for membership. Following that review, your application will go before the committee or subcommittee to which you have applied. You are required to attend the meeting of that committee or subcommittee to introduce yourself and state your interest in serving as a member.

I, (print your full name) \_\_\_\_\_, certify I have thoroughly read this application and will abide by the rules and regulations governing the Miami-Dade HIV/AIDS Partnership. I further certify that all the statements made in this application are true and correct.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Application valid for 6 months from this date.*