



PCHAP
PARTNERSHIP FOR
COMPREHENSIVE
HIV/AIDS PLANNING

Membership Application

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

SECTION 1 - Member Profile

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

Name: _____

Company/Agency: _____

Address: _____

City: _____ State: _____ County: _____ Zip: _____

Phone: _____ Fax Number: _____

Mobile Phone/Pager: _____

E-Mail Address: _____

SECTION 2 - Committee Selection

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

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

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

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

Name (Please Print): _____

Signature: _____

Date: _____

SECTION 3 - Conflict of Interest

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

By my signature below, I certify that:

1. I have read, understand and support Article Four, Section 8 of the Planning Group By-laws and have received, read, understand, and support the Conflict of Interest Policies & Procedures Statement.
2. Listed below is/are organization(s) with which I am presently affiliated. If in the future my affiliation(s) change(s) I will notify the Chair of the Planning Group.

Organization: _____

Title: _____ Period of Affiliation: _____

Organization: _____

Title: _____ Period of Affiliation: _____

Organization: _____

Title: _____ Period of Affiliation: _____

Organization: _____

Title: _____ Period of Affiliation: _____

(Please attach additional pages if necessary)

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

Name: _____ Signature: _____

(print)

Date: _____

SECTION 4: Agency or Other Representation

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

<input type="checkbox"/> Florida Department of Health	<input type="checkbox"/> Department of Corrections
<input type="checkbox"/> Volusia County Health Department	<input type="checkbox"/> Academic Institution
<input type="checkbox"/> Non-Minority Community Based Organization	<input type="checkbox"/> Research Center
<input type="checkbox"/> Minority Community Based Organization	<input type="checkbox"/> Local Government
<input type="checkbox"/> Non-Minority AIDS Service Organization	<input type="checkbox"/> Public Schools
<input type="checkbox"/> Minority Board AIDS Service Organization	<input type="checkbox"/> Persons Living with HIV/AIDS
<input type="checkbox"/> Faith Community	<input type="checkbox"/> HIV/AIDS Affected Community
<input type="checkbox"/> Other Non-Profit: _____	<input type="checkbox"/> Other: _____

Primary and Secondary Expertise

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

<input type="checkbox"/> Licensed Medical Professional	<input type="checkbox"/> Epidemiology
<input type="checkbox"/> Dentist / Oral Health Professional	<input type="checkbox"/> Intervention Specialist
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Program Planning
<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> HIV/AIDS Infected Community (PLWHA)
<input type="checkbox"/> Case Management	<input type="checkbox"/> HIV/AIDS Affected Community
<input type="checkbox"/> Quality Management / Evaluation	<input type="checkbox"/> Other: _____

Planning Body Experience

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

<input type="checkbox"/> HIV/AIDS Prevention Community Planning experience
<input type="checkbox"/> Ryan White Consortium experience
<input type="checkbox"/> Other Planning Body experience: _____

Additional Information

Please describe why you would be an effective representative:
