

Philadelphia EMA Ryan White Part A Planning Council
Application for Membership
Revised August 2013

Please read the entire application BEFORE answering questions

What is the Planning Council?

The Philadelphia EMA (Eligible Metropolitan Area) Part A Ryan White Planning Council makes decisions about funding for HIV care services in Philadelphia, Bucks, Delaware, Chester, Montgomery, Camden, Salem, Burlington, and Gloucester Counties. The council only makes decisions about Part A HIV care services. Part A funds come from the Federal government to provide care for eligible people with HIV/AIDS.

The council does a lot of work to understand the needs of HIV-positive people. The council reviews information on how Part A money is spent and how services are provided, and is federally mandated to prioritize services and allocate funds to service categories. The council does not decide what organizations receive funding.

Who is on the Planning Council?

The people who make up the Planning Council are from Philadelphia, four PA Counties, and four NJ Counties. The council must also be made up of people with different backgrounds and skills. It is important that the Council is made up of people who can represent different communities, cultures, and experiences. *The Ryan White CARE Act (a legislative act, like a law) states that at least 33% of the members must be people living with HIV.*

How can I apply for membership?

If you are interested in applying for membership, **fill out the entire application**. The Nominations Committee will review the application and make recommendations about who should be appointed to the Council. Your information will be kept confidential. You will receive a letter stating your application status. A description of the Nominations Process is available at www.hivphilly.org and from the Office of HIV Planning.

Return the completed application to:

**Office of HIV Planning
340 N. 12th Street, Suite 320
Philadelphia, PA 19107
Phone: 215.574.6760
Fax: 215.574.6761**

If you need any help filling out the application or have a question about the Planning Council, please call 215.574.6760.

FOR OFFICE USE ONLY

Date Received: _____ By: _____ Via: _____
Date Reviewed: _____ Recommended : Y N
Appointed: _____

Please indicate whether you have served on the Council previously.

- _____ I am a new applicant (never been a member of the Planning Council)
- _____ I am a current member of the Planning Council, reapplying for a new term
- _____ I am a former Planning Council member, reapplying (years served _____)

Name (please print): _____

Title (if applicable): _____

Organization (if applicable): _____

I would like to receive my mailings at my: (check one) Organization/Work Home Other

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Area of Residence (check one): Philadelphia Suburb. PA Counties NJ Counties

Primary Phone: _____ Home Cell Work

Is it ok to leave a message on your primary phone? ____ Yes ____ No

Secondary Phone: _____ Home Cell Work

Is it ok to leave a message on your secondary phone? ____ Yes ____ No

Email address: _____

Ethnicity (check one): ____ Non-Hispanic ____ Hispanic

Race

- _____ African American/Black
- _____ Asian/Pacific Islander
- _____ Caucasian/White
- _____ Native American/Alaskan Native
- _____ Multi-racial (specify) _____
- _____ Other (specify) _____

Gender (check one):

____ Male ____ Female ____ Transgender(M to F) ____ Transgender(F to M)

Sexual Orientation (check one):

- _____ Heterosexual/Straight
- _____ Homosexual/Gay/Lesbian
- _____ Bisexual
- _____ Other (specify) _____

Date of Birth:(DD/MM/YY) _____

HIV-status (check one):

- _____ HIV positive
- _____ HIV-positive with AIDS diagnosis
- _____ HIV negative
- _____ Unknown

If you answer HIV-positive or HIV positive with AIDS diagnosis, please fill out the "Authorization to Release Confidential HIV-Related Information" at the end of the application

I am applying for membership on the Planning Council because: (check all that apply)

- I use Ryan White Part A HIV services
- I provide Ryan White Part A HIV services
- I want to give back to my community
- I have a problem/complaint with a service and I want to change things
- I want to have a say in where the funding goes
- Someone asked me to apply
- I want to share my experience and skills with the council to make things better
- I want to learn more about the council and the services offered
- I want to be able to vote at meetings
- I come to meetings all the time and now I want the benefits of membership
- I am directly affected by the HIV epidemic. Someone I know/love is HIV positive
- I can represent an underserved community/population: _____

***In your own words why do you want to join the RWPC:**

Please select all areas of **experience/expertise** that best describe your abilities and experience and indicate your primary or secondary area. It is understood that more than two may apply to you, just select the areas you have greatest strength or most recent experience. Give details about your experience in the space below.

- | | |
|---|---|
| <input type="checkbox"/> Advocacy/Awareness | <input type="checkbox"/> Primary medical care |
| <input type="checkbox"/> Leadership | <input type="checkbox"/> Antiretroviral therapies |
| <input type="checkbox"/> Community organizing | <input type="checkbox"/> Women's HIV health needs |
| <input type="checkbox"/> Health planning | <input type="checkbox"/> Children's health needs |
| <input type="checkbox"/> Evaluation | <input type="checkbox"/> Immigrants and refugee services |
| <input type="checkbox"/> Provider perspective | <input type="checkbox"/> Health needs of Transgender individuals |
| <input type="checkbox"/> Public health | <input type="checkbox"/> Health needs of intravenous drug users |
| <input type="checkbox"/> Youth's HIV health needs | <input type="checkbox"/> Health needs of Men of Color who have sex with men |
| <input type="checkbox"/> Substance use/abuse services and needs | <input type="checkbox"/> Health needs of White men who have sex with men |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Other experience/expertise: _____ |
| <input type="checkbox"/> Homelessness/housing | |
| <input type="checkbox"/> Non-medical support services | |

Of the categories of expertise that you have selected in this section, which one would you consider to be your **PRIMARY** area of expertise?

Of the categories of expertise that you have selected in this section, which one would you consider to be your **SECONDARY** area of expertise?

Please check all groups that you feel you **represent** on the RWPC and indicate your primary and secondary group. You can represent groups either by identifying as a part of a group OR by having experience providing a service or working with a group/community. In the space below please give any details about your experience.

- | | |
|---|--|
| <input type="checkbox"/> Individuals with HIV/AIDS | <input type="checkbox"/> State Medicaid agency |
| <input type="checkbox"/> A community hard hit by HIV/AIDS | <input type="checkbox"/> State agency administering the program under Part B |
| <input type="checkbox"/> Health care provider | <input type="checkbox"/> Part C agencies |
| <input type="checkbox"/> Community-based organizations and AIDS service organizations | <input type="checkbox"/> Part D grantee or organizations serving youth, children and/or families |
| <input type="checkbox"/> Social service providers, including housing | <input type="checkbox"/> Grantee of other federal HIV programs such as AETC, Dental, SPNS, and HOPWA |
| <input type="checkbox"/> Mental health providers | <input type="checkbox"/> Members of Federally Recognized Indian Tribe as represented in the population |
| <input type="checkbox"/> Substance abuse providers | <input type="checkbox"/> Hepatitis B or C or their representatives |
| <input type="checkbox"/> HIV prevention service providers | <input type="checkbox"/> Non-elected community leader (please explain): _____ |
| <input type="checkbox"/> Local public health agency | |
| <input type="checkbox"/> Hospital planning agencies or health care planning agencies | |
| <input type="checkbox"/> HIV+ former prisoners or their representatives | |

Of the categories of representation that you have selected in this section, which one would you consider being the **PRIMARY** area you can represent?

Of the categories of representation that you have selected in this section, which one would you consider being the **SECONDARY** area you can represent?

If you have served on the Planning Council previously, what contributions have you made please indicate two concrete contributions you have made to its activities. (MUST FILL OUT) If you have not served on the Council before, skip this question.

Please list below all organizational affiliations you or a member of your household have with any organization funded by Ryan White Part A:

Organization Name

Relationship of Applicant to Organization

Membership on the RWPC requires that you attend regular meetings of the Planning Council and at least join ONE sub-committee. Meetings are usually in the afternoon. Are you able/willing to make the time commitment necessary to attend meetings regularly?

____ **Yes** ____ **No** If no, please explain:

Have you attended Planning Council, Positive Committee, or other sub-committee meetings before? If so, when and which one(s)?

For accommodation purposes, do you have any special needs i.e. translation & interpretation or a physical disability, etc.? If so, please explain:

What more can we know about you? *You may attach additional sheets*

By my signature below, I certify that I have read and understand the purpose of this form and the definitions contains therein. I further indicate that I understand and agree that my membership on the Planning Council will require a significant commitment of time, including regular training and meeting times each month, additional time for sub-committee and special meetings, and time for reading and reviewing materials. I further confirm that by signing below, I indicate my understanding that I am willing to be publicly known as a member of the Planning Council and to have my HIV status and other demographic information disclosed for the purposes of meeting legislative mandates.

After you read the sections of the Planning Council bylaws attached, sign below if you agree to all these statements.

If appointed to the Planning Council:

1. I will attend all Planning Council meetings, unless excused (corresponding to the bylaws)
2. I will participate on at least one committee.
3. I will attend new member orientation.
4. I will follow the rules and guidelines in the Planning Council bylaws (see attached).
5. My name will be included in meeting minutes (notes) that are a part of public record (Planning Council meetings are open to the public), unless otherwise requested.

Print Name: _____

Signature: _____ Date: _____

Only to be completed by persons indicating they are HIV positive or living with AIDS

**Philadelphia EMA Ryan White Part A Planning Council (Planning Council)
Office of HIV Planning**

340 N. 12th Street, Suite 203, Philadelphia, PA 19107

**AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL HIV-RELATED INFORMATION**

HIV or Human Immunodeficiency Virus is the virus which causes or indicates AIDS or HIV infection.

HIV-related information is information which concerns whether a client/patient has been tested for HIV, or has AIDS or an HIV-related illness, or could reasonably identify the client/patient as having one or more of these conditions.

I authorize **Office of HIV Planning/Philadelphia EMA Ryan White Part A Planning Council (Planning Council)** to release confidential HIV-related information pertaining to me,

(Planning Council Member) _____

(Address) _____

Information regarding my HIV status and demographics may be released to **Health Commissioner's Office, Department of Public Health in Philadelphia**, and the **Health Resources and Services Administration (HRSA)**, by self-report and/or in aggregate form¹ for the purpose of meeting federal and/or local mandates for the representation of key stakeholders. I understand that I may withdraw this consent at any time except to the extent information has already been released in reliance on this form.

This consent will expire upon the termination of membership of the Philadelphia EMA Ryan White Part A Planning Council scheduled to end on _____ day of _____ 20__.

This authorization must be signed and dated.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.

Date: _____
_____ Planning Council Member Signature

Date: _____
_____ Witness Signature

NOTICE OF PROHIBITION OF DISCLOSURE

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS/INFORMATION PROTECTED BY PENNSYLVANIA LAW. PENNSYLVANIA LAW PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR IF AUTHORIZED BY THE CONFIDENTIALITY OF THE HIV-RELATED INFORMATION ACT, 35 P.S. SECTION 7601, ET SEQ. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

¹ This information is generally reported in the form of a percentage of the whole and it is not reported individually.