



Applicant's Name: \_\_\_\_\_

## ORANGE COUNTY HIV PLANNING COUNCIL APPLICATION FOR MEMBERSHIP

**TO APPLY FOR MEMBERSHIP – Send resume, complete and submit the attached:**

- 1) *Application for Membership including the Affirmation of Membership Commitment*
- 2) *Conflict of Interest Worksheet*, and the
- 3) *Conflict of Interest Disclosure Report Form*

**Submit the completed forms and your resumé to HIV Planning and Coordination, 1725-B W. 17th St., Santa Ana, CA 92706 (please do not transmit by facsimile).** If you have any questions, please call (714) 834-8711.

### **HIV PLANNING COUNCIL COMPOSITION**

The Orange County HIV Planning Council has a maximum of 35 and a minimum of 20 voting members. Applicants are selected to fill specific seats to meet mandated categories of membership reflective of the epidemic in Orange County. The Membership Committee reviews all membership applications and recommends candidates to the Planning Council. New members approved by the Planning Council are forwarded to the Orange County Board of Supervisors for appointment. In addition, the Health Officer appoints Affiliate members recommended by the Planning Council.

### **HIV PLANNING COUNCIL COMMITTEES**

Members are expected to serve on at least one of the Council's committees. Committees include: Prevention Planning, HIV Client Advocacy, Housing, and Membership.

### **COUNCIL MEMBERS' ROLES**

The Planning Council decides what services are most needed in Orange County (**set priorities**), decides how much Title I and Title II money should be used for each of these services (**resource allocation**), and develops a plan to provide these services (**comprehensive plan**). These decisions must be made on the evaluation of the needs of people living with HIV (**needs assessment**). The Planning Council also evaluates how efficiently the providers are selected and paid (**assessing the efficiency of the administrative mechanism**). Members also promote public awareness of the HIV epidemic in Orange County.

### **COUNCIL MEMBERS' DUTIES AND RESPONSIBILITIES**

1. Attend a new member orientation session.
2. Develop a working knowledge of the Ryan White CARE Act, Housing Opportunities for Persons with AIDS [HOPWA], the Brown Act, and the community planning process.
3. Learn and use the HIV Planning Council's By-laws, and Policies and Procedures.
4. Attend all scheduled Council meetings and meetings of selected Committees. Estimated time commitment for Council members is four-six hours minimum per month.
5. Participate in the mentoring of new Council members.
6. Take the *Oath of Office* and file Form 700 *Statement of Economic Interest for Designated Parties* upon appointment, annually and at conclusion/resignation.

**Please be advised that your application will be reviewed during public meetings**

Members may be removed from the Council for the following causes: (1) absent three meetings without notice, (2) conduct that disrupts or interferes with the Council or its committees' business.

**Please retain pages 1 & 8 of the application for your records.**



Applicant's Name: \_\_\_\_\_

**ORANGE COUNTY HIV PLANNING COUNCIL**  
**APPLICATION FOR MEMBERSHIP (Please Type or Print)**

- Planning Council Membership       Affiliate Membership       Planning Council Committee

Applicant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Telephone (cell): \_\_\_\_\_ Telephone (home): \_\_\_\_\_

Email: \_\_\_\_\_ Telephone (work): \_\_\_\_\_

Fax: \_\_\_\_\_

May we call you at work?     Yes     No    At home?     Yes     No

May we fax HIV/AIDS-related materials at the above fax number:     Yes     No

May we email HIV/AIDS-related materials?     Yes     No

**CITY OF RESIDENCE (Check one)**

- North County** (Anaheim, Brea, Buena Park, Cypress, Fullerton, La Habra, La Palma, Orange, Placentia, Villa Park, Yorba Linda)
- Central County** (Costa Mesa, Fountain Valley, Garden Grove, Huntington Beach, Irvine, Los Alamitos, Newport Beach, Santa Ana, Seal Beach, Stanton, Tustin, Westminster)
- South County** (Aliso Viejo, Dana Point, Laguna Beach, Laguna Hills, Laguna Niguel, Laguna Woods, Lake Forest/El Toro, Mission Viejo, Rancho Santa Margarita, San Clemente, San Juan Capistrano, Trabuco Canyon)

**PLEASE SELECT WHICH MANDATED CATEGORIES YOU ARE QUALIFIED TO REPRESENT**

- Health care providers, including Federally Qualified Health Centers
- CBOs serving affected populations/AIDS Service Organizations
- Social Service Providers, including housing and homeless service providers
- Mental Health
- Substance Abuse provider
- Local Public Health Agencies
- Hospital planning agencies or health care planning agencies
- Affected communities, including PLWH and historically underserved subpopulations
- Non-elected community leaders
- State Medicaid Agency
- State Title II Agency
- Title III
- Representative of organizations addressing the needs of children, youth, and families with HIV
- Other Federal HIV Programs, including HIV Prevention programs
- Representative of/or formerly incarcerated PLWH

Please describe how you qualify for the category/ies marked:

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**PUBLIC DOCUMENT**

Applicant's Name: \_\_\_\_\_

**Affirmation of Membership Commitment**

**I have reviewed the attached description of the Orange County HIV Planning Council members' roles, duties and responsibilities. I commit to the following:**

- Serve as:  HIV Planning Council Member  Affiliate  Planning Council Committee Member
- Participate in all Council/Committee meetings from beginning to adjournment.
- Prepare for each meeting by carefully reading all pre-distributed materials.
- Provide information regarding needs and priorities.
- Make recommendations *considering the community as a whole rather than just special interests or personal perspectives.*
- Disclose any conflicts of interest I may have relative to issues that come before the Council or Committees.

**I am interested in serving on the following Committee/s:**

Membership  Housing  Client Advocacy  Prevention Planning

**I commit to participating according to the current meeting schedule.** I have considered my personal and professional commitments/obligations and do not foresee them as a barrier to my full participation on the Orange County HIV Planning Council.

***I certify that all statements and representations made in this application are true and correct. Misrepresentation shall be a basis for revocation of my application/membership.***

Print Name: \_\_\_\_\_

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

**Please send your completed application and resumé to:  
HIV Planning & Coordination P.O. Box 6099, Santa Ana, CA 92706-6099**

**PUBLIC DOCUMENT**

Applicant's Name: \_\_\_\_\_

**ADDITIONAL INFORMATION**

Present Employer \_\_\_\_\_

Type of Business/Agency \_\_\_\_\_ Title \_\_\_\_\_

Is your current employment HIV/AIDS related?  Yes  No

Briefly describe your responsibilities.

\_\_\_\_\_

Describe your community involvement. Please identify the organizations or agencies you have served and your participation or membership. Include your activities, responsibilities, accomplishments, and any boards/commissions on which you have served.

\_\_\_\_\_

In 150 words or less, explain why you wish to serve on the Orange County HIV Planning Advisory Council or planning committee. You may attach a separate sheet, if necessary. Please indicate if attaching an addition sheet.

\_\_\_\_\_

\_\_\_\_\_

**PERSONAL PROFILE**

**Gender Identity:**  Male  Female  Transgender  Other

**HIV Status\*:**  Negative  Positive\*\*  Decline to State  Unknown

\*\*If positive, I am a consumer of Ryan White CARE Act funded Service:  Yes  No

\*Information becomes **public record**, please complete attached disclosure form or check "Decline to State"

**Age Group:**  13 – 19  20 – 44  >45

**Cultural/Ethnic Identity\*:**

- African American  Asian (specify): \_\_\_\_\_
- Latino/a (specify): \_\_\_\_\_  Native American (specify Tribe/Nation): \_\_\_\_\_
- Pacific Islander (specify): \_\_\_\_\_  Other (specify): \_\_\_\_\_
- Decline to State

\*If you have any questions about how to report, please refer to [www.census.gov/mso/www/rsf/racedata](http://www.census.gov/mso/www/rsf/racedata), or by telephone at (818) 904-6393.

**Please identify the principal three areas of interest or expertise which you can contribute to the council, entering 1, 2, or 3 (with '1' being the highest):**

- |   |                                    |
|---|------------------------------------|
| _____ Gay/Bisexual men's HIV health needs   | _____ Substance use/abuse services |
| _____ Women's HIV health needs              | _____ Mental Health Services       |
| _____ Pediatric/adolescent HIV health needs | _____ Health Planning              |
| _____ Injecting drug users' health needs    | _____ General Public Health        |
| _____ Other                                 |                                    |

**PUBLIC DOCUMENT**

**ORANGE COUNTY HIV PLANNING COUNCIL**  
 CONFLICT OF INTEREST DISCLOSURE WORKSHEET

This worksheet is to help you to identify any conflicts of interest. After completing the worksheet, transfer to the attached Conflict of Interest Report Form noting those active affiliations **during the preceding 12 months.**

<b>CONTRACTORS</b>
<b>AIDS Services Foundation</b>
<b>Delhi Community Services Center</b>
<b>Orange County Health Care Agency</b>
<b>Public Law Center</b>
<b>Straight Talk (including Gerry House, START House)</b>
<b>Laguna Beach Community Clinic</b>
<b>Shanti, Orange County</b>
<b>The Center, Orange County</b>
<b>UCI Medical Center</b>

1. Are you currently or have you been a member of the Board of Directors of any of the above-listed organizations?  Yes  No
2. Is your spouse, the person assuming the role of spouse, or dependent child currently or have they been in the past a member of the Board of Directors of any of the above-listed organizations?  Yes  No
3. Are you currently or have you been an employee, contractor, a creditor, or consultant of any of the above-listed organizations?  Yes  No
4. Is your spouse, the person assuming the role as spouse, or dependent child currently or have they been in the past an employee, a contractor, or consultant for any of the above-listed organizations?  Yes  No
5. Are you currently or have you volunteered in the past to assist in the policy planning or financial operations to any of the above-listed organizations?  Yes  No
6. Is your spouse, the person assuming the role of spouse, or dependent child currently or have they been in the past a volunteer for any of the above-listed organizations?  Yes  No
7. Do you currently or have you had an economic interest in any of the above-listed organizations?  Yes  No
8. Does your spouse, the person assuming the role of spouse, or dependent child currently have or have they had an economic interest in any of the above-listed organizations?  Yes  No
9. Do you have any other relationship(s) with any of the above-listed organizations that would constitute a conflict? (e.g., are you a member of an advisory committee or board of any of the above-listed organizations)?  Yes  No

IF YOU ANSWERED **YES** TO ANY OF THE ABOVE-LISTED QUESTIONS YOU MUST DISCLOSE A POTENTIAL CONFLICT OF INTEREST. IF A CONFLICT HAS OCCURRED WITHIN THE PAST **12 MONTHS**, THE CONFLICT MUST BE REPORTED ON THE CONFLICT OF INTEREST DISCLOSURE REPORT FORM.

Applicant's Name: \_\_\_\_\_

**ORANGE COUNTY HIV PLANNING COUNCIL**  
**CONFLICT OF INTEREST DISCLOSURE REPORT FORM**

The Orange County HIV Planning Council has members who are professionally or personally affiliated with organizations that have or may request to receive funds that are allocated by the Council. Because of the potential for conflict of interest, current members and candidates for membership on the HIV Planning Council and its committees must complete this Disclosure Form.

Complete either section (A), or section (B) below, as appropriate, and sign/date:

**SECTION A**

*By my signatures below, I certify that:*

I and/or my spouse, or the person assuming the role of spouse, and/or dependent family member(s) have not served within the past 12 months in a staff, consultant, officer, board member for any organization which has received or is seeking funding from the Ryan White CARE or HOPWA funds.

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

Print or Type Name: \_\_\_\_\_

**SECTION B**

*By my signature below, I certify that:*

I and/or my spouse (circle which), or significant other, and/or dependent family member(s) **have served** within the past **12 months** in a staff, consultant, officer, board member for the following organization/s receiving or seeking funding from the Ryan White CARE Act or HOPWA funds.

Organization: \_\_\_\_\_

Period of Affiliation: \_\_\_\_\_

Title/Relationship: \_\_\_\_\_

Organization: \_\_\_\_\_

Period of Affiliation: \_\_\_\_\_

Title/Relationship: \_\_\_\_\_

(Please attach additional pages as necessary)

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

Print or Type Name: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

**AUTHORIZATION TO USE FOR MEMBERSHIP APPLICATION  
AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**

**APPLICANT INFORMATION:**

NAME: \_\_\_\_\_  
Last First M.I. Also Known As (if you have used other names): \_\_\_\_\_  
Date of Birth (Optional): \_\_\_\_\_

**PURPOSE OF THE DISCLOSURE OF Personal Health Information:** If I wish to be considered for membership or affiliate status as a consumer representative, it is necessary to identify my HIV + status. Consumers are individuals "receiving HIV-related services from Title I providers" and include PLWH/A receiving services themselves and the parents and caregivers of minor children who are receiving such services. Consumers are further defined as unaligned. "Unaligned" means you have no financial or governing interest in Title I funded agencies.

By signing this authorization, I willingly disclose my status for application purposes. I understand that this information will become public record and will be discussed in open, public meetings. The Ralph M. Brown Act requires open discussion in a public forum.

If I choose not to disclose my HIV status, I will still be considered for membership on the Orange County HIV Planning Council in other (non-consumer) membership categories, provided there is an open seat.

I, the undersigned, hereby **voluntarily** authorize the DISCLOSURE of my HIV serostatus [Protected Health Information] to:

**HIV Planning Council / PUBLIC RECORD  
P. O. Box 6099  
Santa Ana, CA 92706-0099**

**Redisclosure of a person's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by California or federal law.**

Specific Type of Information to be released

HIV Status:  Positive

Another membership category is: a representative of individuals who were formerly Federal, State, or local prisoners, were released from custody of the penal system during the preceding three years, and had HIV disease as of the date of release. If you wish to be considered as a representative of that group, please answer the following question.

Are you a former Federal, State, or local prisoner, released from the custody of the penal system during the last three years, and had HIV-disease on the date of release?  Yes  No

**You may revoke this authorization to disclose PHI in writing prior to your application being considered at the next Membership Committee meeting. Contact the OC HIV Planning & Coordination office at 714-834-8711 to obtain the form. However, the information may have already been disclosed on the basis of this authorization.**

**THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT UNTIL REVOKED. INFORMATION PLACED IN THE PUBLIC RECORD, HOWEVER, CANNOT BE REMOVED. UNLESS OTHERWISE REVOKED IN WRITING, THIS AUTHORIZATION EXPIRES ON:**

Completion of this request (one time disclosure) **OR**  Six months from signature date below.

**TODAY'S DATE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**COMPLETE ADDRESS:** \_\_\_\_\_ **TELEPHONE #:** \_\_\_\_\_

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)  
YOU HAVE A RIGHT TO RECEIVE A COPY OF THE AUTHORIZATION PHOTOCOPY/FACSIMILE.  
COPY MAY BE USED AS AN ORIGINAL.**

Applicant's Name: \_\_\_\_\_

**AUTHORIZATION TO USE FOR MEMBERSHIP APPLICATION AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**

**APPLICANT INFORMATION:**

NAME: \_\_\_\_\_ Also Known As (if you have used other names): \_\_\_\_\_  
Last First M.I. Date of Birth (Optional): \_\_\_\_\_

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**TODAY'S DATE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**COMPLETE ADDRESS:** \_\_\_\_\_ **TELEPHONE #:** \_\_\_\_\_

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YOU HAVE A RIGHT TO RECEIVE A COPY OF THE AUTHORIZATION PHOTOCOPY/FACSIMILE.  
COPY MAY BE USED AS AN ORIGINAL.**



Applicant's Name: \_\_\_\_\_

Health Care Agency  
PUBLIC HEALTH SERVICES

# MEMO

HIV Planning and Coordination

Please provide your name and address if you wish to be notified by U.S. mail service

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Or, if you would prefer electronic notification, please clearly write your email address:

\_\_\_\_\_

Per the Membership Committee of the OC HIV Planning Council [HPC] directive of March 28, 2003, this is notice will be sent, either by U.S. mail or electronically to acknowledge receipt of your application for:

- Planning Council Voting Membership
- Planning Council Affiliate Status
- Planning Council Committee Membership on:
  - Membership
  - Housing
  - Client Advocacy

The Membership Committee and/or this Office will keep you apprised of the status of your application. Do not hesitate to contact this office if you have any questions, or if some one may be of further assistance to you. If you have not received notice from this office confirming receipt of your application by ten (10) working days, please telephone (714) 834-8711. Thank you for your interest to serve on the HPC.

HIV Planning & Coordination