Application for Membership

HIV Integrated Planning Council (HIPC)

The Philadelphia Eligible Metropolitan Area

Revised October 2017

Please read the entire application BEFORE answering questions

What is the Planning Council?

The HIV Integrated Planning Council is composed of members representing both prevention and care service providers and service recipients. Currently, the prevention representation is made up of the group formerly known as; the Philadelphia HIV Prevention Planning Group (HPG).The care representation consists of the group formerly known as; the Philadelphia EMA (Eligible Metropolitan Area) Ryan White Part A Planning Council. The HIPC is responsible for decisions about funding for HIV care services in Philadelphia, Bucks, Delaware, Chester, Montgomery, Camden, Salem, Burlington, and Gloucester Counties. The HIPC makes decisions about Part A HIV care services and reviews proposed prevention activities. Part A funds come from the Federal government (Health Resources and Services Administration) to provide care for eligible people with HIV/AIDS. Federal Funding for prevention comes from the Centers for Disease Control (CDC).

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. They are all volunteer positions appointed by the Mayor of the City of Philadelphia. To satisfy the federal requirements 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 is represent different communities, cultures, and experiences. *At least 33% of the members must be people living with HIV based on the Public Health Services Act, HIV Services Program legislation.*

How can I apply for membership?

Applications are accepted throughout the year. Reviews and recommendations are made twice a year (or by special appointment). 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. 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 _____)

Personal Information

Full 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: this is my ☐Home ☐Cell
☐Work

Secondary Phone: this is my ☐Home ☐Cell
☐Work

Email Address:

Demographic Information

Race (check one):

☐ African American/Black
☐ Asian / Pacific Islander
☐ Caucasian/White
☐ Native American or Alaska Native
☐ Multi-racial (specify):
_____
☐ Other (specify):
_____

Gender:

☐ Male
☐ Female
☐ Transgender (female to male)
☐ Transgender (male to female)
☐ Other (specify):
_____

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

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Sexual Orientation (check one):

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

Date of Birth:

_____
(DD/MM/YY)

Reason for Applying

***In your own words why do you want to join the HIPC:** *(you may attach additional sheets)*

_____

_____

_____

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: _____

Affiliation/Representation and Expertise

Please fill in each column below, checking all that apply to you 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 expertise or representation.

Experience/Expertise:

- ☐Children's /Youth's HIV health needs
- ☐Health needs of Transgender individuals
- ☐ Health needs of people who inject drugs(PWID)
- ☐Health needs of Men who have sex with men (MSM)
- ☐Immigrants and refugee services
- ☐Women's HIV health needs
- ☐Homelessness/housing
- ☐Mental Health
- ☐Primary medical care
- ☐Substance use/abuse services and needs
- ☐Behavioral/Social Science
- ☐Community organizing
- ☐Education or training
- ☐Evaluation
- ☐Epidemiology
- ☐Health planning
- ☐Provider perspective
- ☐Public health
- ☐Non-medical support services

From above choices, indicate your PRIMARY area of expertise:

_____

Indicate a SECONDARY expertise:

_____

Representation/Affiliation:

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

From above choices, indicate your PRIMARY representation:

_____

Indicate a SECONDARY representation:

_____

Additional Information

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 HIPC 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

Check off meetings you have attended:

☐ Planning Council
☐ Positive Committee
☐ Comprehensive Planning
☐ Finance
☐ Needs Assessment
☐ Nominations
☐ Prevention Committee
☐ Never attended a meeting

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 OR personal statement. *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, 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:_____

HIV Integrated Planning Council (HIPC)
Application for Membership
Additional Information *(updated January 2017)*

In order to comply with the legislative language all recommended applicants would need to receive an official appointment letter from the Office of Mayor of Philadelphia. The City requires that appointed individuals complete the tax and water clearance process. We ask applicants to include the clearance certificate along with their HIPC membership application.

Instruction on obtaining the tax and water clearance certificate:

Step 1 - Go to www.phila.gov/revenue

Step 2 - Click on to a link titled 'Get Tax Clearance' on following screen click 'City of Philadelphia tax clearance system.'

Step 3 - click 'Accept.'

Step 4 - click on the drop down menu titled 'Select Compliance Type,' please choose 'Executive Board.'

Step 5 - Leave the BRT/OPA# entry box empty. Enter your address and Zip Code. For Entity Ownership drop down menu, select if you are an owner or tenant.

For Entity Name, please enter your full Name and for Entity ID you need to enter your Social Security Number (ignore Entity Type). Click on 'Search.'

You can screen shot your certificate or print– please retain a copy.

Please check off the follow that apply to you:

___ I was able to obtain the tax and water clearance certificate and it is attached.

___ I will need assistance in completing the tax and water clearance process.
(Please contact the Office of HIV Planning upon submitting this application for assistance)

_____ _____
Name Date

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

HIV Integrated Planning Council *(Planning Council)*
Office of HIV Planning
340 N. 12th Street, Suite 320, 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/HIV Integrated 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, Philadelphia Department of Public Health*,*** and the ***Health Resources and Services Administration (HRSA),*** by self-report and/or in aggregate form[1] 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 HIV Integrated 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 IN NOT SUFFICIENT FOR THIS PURPOSE.

[1] This information is reported in the Program Terms Report submitted annually to HRSA otherwise all member status information is provided in aggregate form.

HIV Integrated Planning Council Confidentiality Agreement

I. Purpose. The purpose of this Confidentiality Agreement is to protect the identity and privacy of our existing members and applicants. Staff and volunteers of the HIV Integrated Planning Council (HIPC) encounter and review personal and sensitive information about our existing members and applicants. This is particularly true because a large portion of our membership consists of people who are living with HIV or may be affected by HIV.

II. Confidential Information. Confidential member or applicant information should never be discussed in the presence of parties other than current OHP staff or HIPC volunteers, except under the Terms outlined below. Any files and /or documents should never be shared or released to third parties, except under the Terms outlined below. Confidential information includes, but is not limited, to the following:

- Information identifying the member or applicant as a person living with HIV
- Information regarding any other medical information
- Information regarding the member or applicant's gender identity
- Information regarding the member or applicant's sexual orientation
- Information regarding the member or applicant's immigration status

III. Terms. By signing this Confidentiality Agreement, you agree to the highest ethical standards and to abide by the following provisions:

- All communications between OHP staff, HIPC volunteers related to fellow members or applicants are confidential
- The OHP staff or HIPC volunteer shall not disclose confidential information to a third party without the member or applicant's express consent to release such information
- I understand that, as OHP staff or HIPC volunteer, I have a duty to keep member or applicant information confidential throughout my term as a staff or volunteer as well as after my employment or volunteer status end
- I understand that my failure to abide by the terms of this Confidentiality Agreement may result in the termination of my employment at OHP or volunteer membership with the HIPC

I, _____, have read the HIPC Confidentiality Agreement and understand its terms and my responsibilities as an OHP employee or HIPC member volunteer.

_____ Date:_____

Signature of Staff or Volunteer