

# Area 15 Comprehensive Planning Network (CPN) Membership Application

**SERVING INDIAN RIVER, MARTIN, OKEECHOBEE, AND ST. LUCIE COUNTIES**

**Address:** Florida Department of Health in St. Lucie County, 5150 NW Milner Drive, Port Saint Lucie, FL 34983 **Phone:** 772-584-9141 **E-Mail:** [planning@hcsef.org](mailto:planning@hcsef.org) **Fax:** 561-844-3310 **Website:** [Area15CPN.org](http://Area15CPN.org)

## Applicant Information

*To help the Consortia support staff and the Membership Committee process your membership application, please provide all of the information requested and type or print clearly.*

Full Name:                      *Last*    *First*    *M.I.*

Address: *Street Address*

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone Number:     (      )                                  Email:

Business Name:

Business Address: *Street Address* *Suite/Unit #*

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Business Phone:     (      )                          Business Email:

## Tell us about yourself

*Your responses will be kept CONFIDENTIAL and available only to the Consortia support staff and the Membership Committee.*

### Racial or Ethnic Group

American Indian/Alaskan

Asian/Pacific Islander

Black/African American

Hispanic/Latino

White/Caucasian

Other/Specify \_\_\_\_\_

Do not wish to disclose

## Gender

Male

Female

Transgender

**Date of Birth**

DOB (mm/dd) \_\_\_\_\_

## OPTIONAL

If you are a person living with HIV, are you willing to self-identify as such for Area 15 HIV/AIDS Comprehensive Planning Network activities?\*

Yes

No

Not Applicable

Please indicate if any of the following apply\*

HIV Positive

## Living with AIDS

Other (please specify):

*\* Disclosure of HIV status is encouraged, but not required for membership.*

## Committee Interest (MANDATORY - Please choose only one.)

*The Area 15 Comprehensive Planning Network General Body meets every two months (currently on the 4th Tuesday) via Zoom from 11:00 AM - 12:00 PM. The Committees meet monthly (currently on the 2nd Thursday) via Zoom - the Membership Committee meets from 10:00 AM - 11:00 AM while the Evaluation Quality Assurance/Planning Committee meets from 11:00 AM - 12:00 PM.*

### Member Conflict of Interest Declaration

I, the undersigned hereby affirm that neither I, nor any member of my family, agency or employer:  
(please check applicable statement)

- ☐ Will **NOT** benefit from business conducted by myself as a member of the AREA 15 HIV/AIDS Comprehensive Planning Network
- ☐ Will benefit from business conducted by myself as a member of the AREA 15 HIV/AIDS Comprehensive Planning Network

Describe potential conflict and names of persons involved:

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I understand and agree to notify the AREA 15 HIV/AIDS Comprehensive Planning Network in writing upon any changes in the above conflict of interest.

Printed Name of Applicant: \_\_\_\_\_

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

### Memorandum of Understanding Confidentiality of Client Information

The purpose of the Memorandum of Understanding is to emphasize that all information held in client records is confidential, with access governed by state and federal laws. Information which is confidential includes a client's name, address, date of birth, medical, social, and financial data, and services received. In addition, the fact that someone has had an HIV test is confidential, whether the result of that test is positive, negative or if there is a client self-disclosure. Data collection by interview, observation or review of documents should be conducted in a setting that protects the client's identity from unauthorized individuals.

Section 384.29, Florida Statutes, address the need for special discretion in the handling of sexually transmissible disease information. Sexually transmissible disease, by their nature, involves sensitive issues of privacy and all programs designed to deal with these diseases should afford privacy and confidentiality to the client.

Section 381.609, Florida Statutes, deals with confidentiality of HIV test results. There are penalties for violating this statute. These penalties range from disciplinary action by agency to a criminal misdemeanor.

I understand and agree to abide by these confidential provisions.

Organization Name (if applicable): \_\_\_\_\_

Printed Name of Applicant: \_\_\_\_\_

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

This information is being requested in accordance with federal regulations. The information is kept private and will not be used when considering you for membership.



## AREA 15 HIV/AIDS Comprehensive Planning Network **GROUND RULES**

We are operating under the sunshine law and Roberts Rules of Order. This is a public meeting. Information discussed during meetings is subject to public records disclosure.

1. One person speaks at a time; others listen and do not interrupt.
2. Each person speaks for himself or herself, do not claim to speak for others unless you are delegated to do so.
3. Be polite. It's acceptable to disagree but do so respectfully. Insults and accusations are unacceptable
4. Share group time fairly. Allow everyone a chance to speak and listen.
5. Be open to listening to and learning from others' viewpoints.
6. When the Network is locked in conflict, agree to stop the agenda and brainstorm creative options.
7. Refer to the Network's written policy and procedures for handling conflict that cannot be resolved in a regular meeting.
8. Allow adequate agenda time for particularly sensitive issues. Make sure that each person has time to discuss all aspects of the issue without unrealistic time constraints being imposed.
9. Clarify who will monitor group interactions for compliance with the ground rules and agree to what happens to repeat offenders
10. I understand and agree to abide by the AREA 15 HIV/AIDS Comprehensive Planning Network Ground Rules.

Printed Name of Applicant: \_\_\_\_\_

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