Central Florida HIV Planning Council

CONFLICT OF INTEREST DISCLOSURE FORM

A conflict of interest in an actual or perceived interest in an action that will result or has the appearance of resulting in personal, organizational, or professional gain (i.e., members who serve as director, trustee, board member, salaried employee, subcontractor, or immediate family member*), or otherwise materially benefit from association with any agency receiving or seeking Ryan White Part A, Part B, Part C, Part D, and/or Part F funding is deemed to have an "interest" in said agency or agencies. Conflict of Interest does not refer to PLWH whose sole relationship to a Ryan White Part A, Part B, Part C, Part D, and/or Part F funded provider is as a client or serving as an uncompensated volunteer.

I am or have been affiliated within the last six (6) months with the following organization:

►Organization: _____

Position: _____ From: ____To: _____

►Organization: _____

Position: _____ From: ____To: _____

A member of my immediate family is or has been affiliated within the last six (6) months with the following organization:

►Name of Family Member: _____ Relationship: _____

►Organization: _____

Position: _____ From: _____To: _____

►Organization: _____

Position: _____ From: ____To: _____

○ **I do not have an ACTUAL or PERCEIVED Conflict of Interest in any of the following Service Categories**

○ **I have an ACTUAL OR PERCEIVED Conflict of Interest in the following Service Categories:**

Actual	Perceived	Core Medical Services
		Outpatient Ambulatory Health Services (OAHS)
		AIDS Pharmaceutical Assistance
		Oral Health Services
		Early Intervention Services (EIS)
		Health Insurance Premium Assistance
		Medical Case Management
		Mental Health Services
		Medical Nutrition Therapy
		Substance Abuse Outpatient Care
		Other:

Actual	Perceived	Support Services
		Substance Abuse (Residential)
		Non-Medical Case Management
		Food Bank/Home Delivered Meals
		Housing Services
		Psychosocial Support (Peers)
		Medical Transportation
		Emergency Financial Assistance
		Referral for Health Care and Support Services
		Health Education/Risk Reduction
		Other:

Name (PRINT): _____

Signature: _____ **Date:** _____

Planning Council member affiliations:

I am or have been affiliated within the last six (6) months with the following organizations:

►Organization: _____

Position: _____ From: _____ To: _____

►Organization: _____

Position: _____ From: _____ To: _____

►Organization: _____

Position: _____ From: _____ To: _____

Family member affiliations:

A member of my immediate family is or has been affiliated within the last six (6) months with the following organization:

►Name of Family Member: _____ Relationship: _____

Organization: _____

Position: _____ From: _____ To: _____

►Name of Family Member: _____ Relationship: _____

Organization: _____

Position: _____ From: _____ To: _____

►Name of Family Member: _____ Relationship: _____

Organization: _____

Position: _____ From: _____ To: _____

Name (PRINT): _____

Signature: _____ **Date:** _____

Membership Application