# BYLAWS

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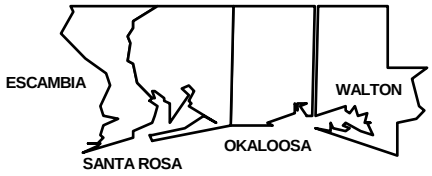
# Northwest Florida AIDS Consortium (NoFLAC)



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## ARTICLE ONE – Name and Headquarters

The name of the organization will be known as The Northwest Florida AIDS Consortium, herein referred to as "the Consortium" for the purpose of these bylaws. The administrative office will be located at the Lead Agency in the designated service area for the purposes of maintenance of records and coordination of activities or at some other location as may be determined from time to time by the Consortium.

## ARTICLE TWO – Mission and Vision

### Section 1: Mission Statement

The mission of the Consortium is to plan a comprehensive array of HIV/AIDS services spanning from prevention to early intervention and patient care through active, open and inclusive community planning processes that emphasize delivery of quality and effective services to all clients and communities affected by HIV/AIDS within the boundaries of DOH Area 1 (Escambia, Santa Rosa, Okaloosa and Walton counties).

### Section 2: Vision Statement

The vision of the Consortium is: "Public and private individuals and agencies working cooperatively in an atmosphere of mutual trust, dignity and respect to plan a seamless continuum of accessible, high quality services for all people of Area 1 affected by HIV/AIDS across the lifespan."

## ARTICLE THREE – Roles and Objectives

The role of the Consortium in the planning process is to:

1. Participate in the development, implementation, evaluation and updating of the Local Comprehensive Plan for people with HIV/AIDS.
2. Identify essential service needs and assess community resources.
3. Prioritize HIV/AIDS services needs for all populations.
4. Provide recommendations regarding the percent allocation of Ryan White CARE Act funds to prioritized service categories.
5. Promote greater cooperation among all agencies delivering HIV-related health and human services.

## ARTICLE FOUR – Membership and Responsibilities

**Section 1: Composition of Members –** The Consortium membership should include organizations public and private, with interest or experience in HIV/AIDS service delivery and populations and subpopulations of persons living with HIV/AIDS (PLWHA) and/or persons affected by HIV/AIDS. In order to ensure diverse experience and input, members should be representative of, but not limited to the types of organizations and expertise recommended in the most current guidance from both the Health Resource Service Administration (HRSA) and the Centers for Disease Control and Prevention (CDC). The Consortium Membership will strive for a minimum of 25% PLWHA or persons affected by HIV/AIDS.

**Section 2: Eligibility –** The Consortium shall be open to any individual residing or working in Area 1 who demonstrates affirmative interest and concern to improve the health of people living with HIV/AIDS. Only those individuals who have attended at least two of the last four Consortium meetings will be eligible to vote. No more than two paid staff members from any one organization who are not self identified PLWHAs may be voting members of the Consortium.

**Section 3: Attendance & Voting Privileges –** Individuals who have completed the Consortium membership application and attended two of the last four full consortia meetings may vote. Any person living with HIV/AIDS who is unable to physically participate in activities may receive special exemption to

participation requirements and as active members shall be allowed representation by proxy. Members are encouraged to select and participate in one Primary Standing Committee and should attend all regularly and duly called meetings of that committee.

**Section 4: Recruitment of Members –** All Consortium members will be responsible to assist in the recruitment of individuals from all represented geographic areas, infected and affected population groups and various fields of expertise, including people who have an interest in the health of persons living with HIV/AIDS.

**Section 5: Duties –** Active Voting Members agree to participate in the planning, implementation and evaluation of a comprehensive service plan for people living with HIV/AIDS and participate actively on at least one Primary Standing Committee.

**Section 6: Membership Terms and Resignation –** Active Voting Membership terms shall be perpetual unless otherwise provided by these bylaws. Any member may at any time resign as a member by submitting a written resignation to the Chair to be effective upon receipt.

**Section 7: Removal of Members –** Any member may be removed with cause, by a majority vote of the Consortium Steering Committee where a quorum (33%) of all current voting Steering Committee members is present.

**Section 8: Conflict of Interest –** In the conduct of all business, the Consortium will act in accordance with all local and state laws pertaining to conflicts of interest. In order to safeguard Consortium recommendations to the Department of Health from potential conflict of interest, each member will disclose any and all professional and/or personal affiliations with agencies that may pursue funding from the Department of Health, from the Department of Health's agents, or from other agents as might be affected by the recommendations of the Consortium.

> **Section 8a:** Each member will complete a Disclosure Statement form annually indicating their willingness to leave behind special interest of their agency during planning deliberations and agree to act only on behalf of the broadly affected HIV community. All completed Disclosure Statement forms will be kept on file by the Lead Agency. A review of the conflict of interest policy and procedures will be conducted during at least one meeting of the Consortium in each calendar year.
>
> **Section 8b:** A Consortium Voting Member who also serves as a director, trustee, board member, or a salaried employee or otherwise materially benefits from association with any agency which may seek funds from the Lead Agency is deemed to have an "interest" in said agency or agencies regardless of HIV status.
>
> **Section 8c:** All Consortium members with a conflict of interest shall abstain from voting on issues that relate to the source of conflict. A member may be removed from the Consortium and all Committees when it is determined that the members knowingly attempted to influence the Consortium in an area of conflict of interest.
>
> **Section 8d:** The Consortium Chair has the prerogative of calling for a vote to determine whether a member will have voting privileges on any issue(s) in question.

## ARTICLE FIVE – Governance of Meetings

The Voting Membership will elect a Chair and Vice-Chair. The Chair shall preside over full meetings of the Consortium. In the absence of the Chair, the co-Chair shall preside over full meetings.

All business that may come before the Consortium will be addressed with an open consensus-building decision–making process. Should consensus-building activities fail to facilitate the effective conduct of any business at hand, the Chair, at their discretion may elect to conduct a meeting or any part thereof, according to the procedures established in the current edition Robert's Rules of Order, Newly Revised.

**Section 1: Schedule of Meetings –** The Consortium voting membership meetings will meet quarterly in January, April, July, and October to conduct regular business. Should the business to be addressed by the consortium be less than or more than usual, the Chair may postpone, cancel or schedule meetings as needed. We will strive to hold two of the four meetings in Fort Walton Beach to accommodate consumers and staff from the eastern half of Area One.

**Section 2: Meeting Venues –** All Consortium meetings are open to the public. The Consortium will meet in locations and at times that are convenient to the general public whenever possible.

**Section 3: Emergency Meetings –** Meetings to address urgent business may be called as needed by the Chair. At the discretion of the Chair, urgent business may be addressed through:

a) Audio or audio/video conferences with available Consortium members, or
b) Through a diligent polling of all voting members by the Chair or their designees.

All such urgent business and the process by which decisions are reached must be fully and completely documented and submitted to the Consortium for review at the next regularly scheduled meeting.

**Section 4: Meeting Notices –** Notices of regularly scheduled meetings will be publicly posted at least 10 days before a meeting is to be held. Notification of meetings and other information pertaining to the Consortium will be mailed or emailed directly to the Consortium members no later than two weeks prior to the meeting by the Lead Agency.

**Section 5: Decision Making –** The decisions of the Consortium and Committees will be based primarily on consensus building that takes place during duly called meetings at which a quorum (33%) of all current voting members is present. Should the voting members fail to reach a consensus within a reasonable amount of time as determined by the Chair, the Chair may, at their discretion, invoke Robert's Rules of Order, Newly Revised, and call for a vote on the question to be determined. Any voting member may all for a vote on any specific issue by putting forth a motion. A simple majority of votes cast on any such issue shall be sufficient to decide the issue. The Chair shall abstain from voting in such instances, unless their vote would either cause or break a tie, in which case the Chair may use their discretion in voting.

## ARTICLE SIX – Committees

**Section 1: Primary Standing Committees –** Members must select a Primary Standing Committee on which to participate. It is recommended that at least 25% of all Committees be people living with HIV/AIDS or affected by HIV/AIDS. Committees will meet as determined by the needs of the Consortium.

The decisions of each committee will be based primarily on consensus building that takes place during duly called committee meetings at which a quorum (33%) of all current voting members is present. Should the voting members fail to reach a consensus within a reasonable amount of time as determined by the Committee Chair, the Chair may invoke Robert's Rules of Order, Newly Revised and call for a vote on any specific issue by putting forth a motion. A simple majority of votes cast on any such issue shall be sufficient to decide the issue. The Committee Chair shall abstain from voting in such instances, unless the Chair's vote would either cause or break a tie, in which case the Chair may use their discretion in voting.

**Section 1a: Needs and Resources Committee –** The purpose of the Needs and Resources Committee is to conduct an annual Resource Inventory of all HIV/AIDS services and determine the needs of the clients

and communities served by HIV/AIDS services (through focus groups, surveys, interviews, and other acceptable methods) and guide the Needs Assessment processes utilized by the Lead Agency. The Area 1 Prevention Planning Group is synonymous with this committee by virtue of its function and activities and is hereby incorporated by reference.

**Section 1b: Consumer Advisory Group (CAG) Committee** – The Consumer Advisory Group (CAG) Committee shall serve as NoFLAC's official "Quality Management" monitoring agent for all RW client services. To this end, they will annually organize two "Consumer Caucus" meetings to solicit feedback from Area One Consumers regarding their satisfaction/dissatisfaction with services provided and/or needed. In addition, they will review the most current "Consumer Satisfaction Surveys" and most recent "Needs Assessment". The feedback received from the Consumer Caucus meetings will be compiled in a report by the CAG Chair and forwarded to the Chair and Co-chair of NoFLAC, the DOH HAPC and Contract Manager, and the Lead Agency. All three entities shall then work together to seek improvement to services in terms of improved policy, consumer access, and or quality issues relevant to the feedback received from Consumers. The NoFLAC Chair and Co-chair shall provide the CAG Committee Chair and membership with timely feedback regarding any implemented changes to improve service quality to consumers. These efforts should not be limited to the two Consumer Caucus Committee meetings, but rather "continual" in nature when any issues arise through consumer feedback at quarterly Consortium Meetings, or when brought the attention of the CAG Subcommittee Chair. In addition, the CAG committee shall strive to assure that all processes are clear and as simple as possible to assure consumer understanding---and information is delivered consistently to consumers regardless of Case Management Organization. Finally, the CAG will strive to assure protection of identity to the greatest degree possible in the interest of minimizing any fears of clients related to making any complaints---assuring anonymity when possible, especially at the two annual "Consumer Caucus" meetings. The goal would be the establishment of "trust and a safe space" for consumers to give open and honest feedback and increase continual consumer representation and feedback into our service delivery continuum.

**Section 1c: Prevention Planning Group** -- The "HIV Prevention Planning Group" Committee will work at a community level to support the goals of our DOH Statewide Prevention Planning Group including, but not limited to: 1) encouraging broad-based participation in HIV prevention planning, 2) identifying priority HIV population(s) and their respective needs and "best practices" for prevention interventions, 3)ensuring that HIV prevention resources target the identified community priority populations and proposed interventions set forth in the comprehensive HIV prevention plan. This committee will be chaired by the "Statewide Prevention Planning Group" representative recommended by the Consortium. This committee will also be responsible for keeping the general membership of the Consortium informed as to both Statewide and community HIV prevention initiatives, etc.

**Section 2: Steering Committee -** The Chair of the Consortium will serve as the Chair of the Steering Committee. The Steering Committee will consist of the Officers of the Consortium and the Chairpersons of each committee. The Steering Committee will oversee the overall community planning process, maintain the bylaws, recruit new members, review conflict of interest claims and provide input to the Lead Agency as needed.

The Committee will review and update bylaws annually or as needed. The Committee will accept written requests for proposed bylaw changes from any active Consortium member, review each request, draft changes, if any, and present the draft recommendations to the Consortium for a final vote.

The Committee will also review and update annually, or as needed, the conflict of interest policy and distribute to all Consortium members. The Committee will review potential conflicts of interest according to established policies and procedures at the request of any active Consortium member.

Vacant Committee Chair positions will be selected and appointed by the Steering Committee in accordance with the by-laws. In the event a Vice-Chair resigns or is no longer able to fulfill their duties, the Steering Committee will convene within 30 days or prior to the next Consortium meeting (whichever comes first) and a replacement will be selected from within its ranks.

**Section 3: Secondary Committees –** The secondary committees are: Priorities and Allocations, Nominating and Ad-Hoc. The Consortium recommends that at least 25% of all Committees be people living with HIV/AIDS or affected by HIV/AIDS.

**Section 3a: Priorities and Allocations –** The Priorities and Allocations Committee will conduct priority setting and allocation tasks as required by the Florida Comprehensive Planning Network for the Bureau of HIV/AIDS for the Ryan White Part B funding, as well as by other funding sources. At least 25% of the Priorities and Allocations Committee members **must** be people living with HIV/AIDS. In determining priorities and allocations, the Committee will rely on the work produced by the needs assessment process which will have direct input from consumers, local AIDS services organizations and the Health Department. Consortium Bylaws will guide Conflict of Interest. All committee members will review their Conflict of Interest statements to insure that they are current and all committee members will complete Conflict of Interest forms. All committee members should place the needs of the entire HIV population above any specific concerns. No more than one member from any agency may vote on the committee. Agency representatives will determine and notify the chair which member will vote. Committee members who are also Ryan White Part B service providers may not vote on their own service categories and are expected to treat all categories fairly. The chair will enforce the conflict of interest policy with the assistance of other committee members. Any committee member who believes a conflict of interest exists is expected to raise his/her concern immediately so that it may be resolved. Clients/consumers do not incur a conflict of interest merely by receiving services from an agency, but **DO** have a conflict if they are employed by, or are a member of the Board of Directors of an agency. Committee members must be present to vote. Active Committee members are those who have attended two of the last four most recent meetings, including the current meeting. Recommendations to the full Consortium from the Priorities and Allocations Committee will be subject to a strict "up or down" vote (approval or rejection) and may not be amended or modified by the consortium and if rejected will be sent back to the Committee.

**Section 3b: Nominating Committee -** The Nominating Committee is comprised of no more than five members to identify and present a slate of officer nominees to the Consortium. The Nominating Committee will prepare and publicize a potential slate of officers during July in advance of the October election. Nominations for all officers will also be accepted from the floor at the July meeting prior to the meeting in October. Chair of the Nominating Committee shall be an active voting member selected by voting members during the Consortium meeting and will serve as ex-officio on the Steering Committee. The Nominating Committee convenes in April and prepares a slate of officers to present to the Consortium in July for election in October.

**Section 3c: Ad-Hoc Committees –** The Chair may appoint Ad-Hoc committees as he or she deems necessary to address issues that do not logically fall under another committee, or issues that require immediate attention and cannot be addressed by another committee. In appointing such Ad-Hoc committees, the Chair will set a specific task to be completed with an initial timeline for the committee to report back to the Consortium. Ad-Hoc Committees tend to be short in their duration. During the time an Ad-Hoc Committee is constituted, the Chair of that committee shall serve on the Steering Committee.

## ARTICLE SEVEN – Officers

**Section 1: Elections –** The Consortium shall elect a Chair and Vice-Chair from the membership at an annual meeting in odd-numbered calendar years, with a quorum present. The officers shall be elected by a majority of the votes cast. The Nominating Committee will prepare and publicize a potential slate of officers during July in advance of the October election. Nominations for all officers will also be accepted from the

floor at the July meeting prior to the meeting in October. Candidates receiving the highest number of votes of the eligible voting members present shall be deemed elected. In the event of an unexpected vacancy (occurring for any reason including death, incapacity, or resignation) of the Chair, the Vice-Chair shall serve the unexpired term of the Chair. If both Chair and Vice-Chair positions are vacated, the Lead Agency may appoint a willing member to serve as Chair to complete the unexpired term with consent of the majority of Consortium members present at a regular meeting.

The officers will be elected for a two year term. No officer shall hold the same office for more than two consecutive terms. The officers will guide the Consortium in achieving its mission and goals.

Minimum qualifications for the officers include being a resident of Area 1 counties and participation as an active voting member of the Consortium for at least one year.

**Section 2: Duties of Officers**

**A. Chair:** The Chair's duties and responsibilities will be to:

- Represent the Consortium to the State of Florida, the Health Department and to other organizations and interested parties.
- Preside at the monthly meetings of the Consortium and the Steering Committee.
- Be an ex-officio member of all committees.
- Have the authority to break a tie or cause a tie in votes at the Consortium and Steering Committee meetings.
- Delegate responsibilities, as appropriate, to the Vice Chair and other members of the Consortium.
- The Chair will set the agenda for Consortium Steering Committee meeting.

**B. Vice-Chair:** The Vice-Chair shall serve in the absence or disability of the Chair. This designee shall perform all powers and duties of the office. In the event the office of the Chair of the Consortium becomes vacant, the Vice-Chair shall serve the un-expired term but this shall not be considered a full term.

**C. Removal of Officers:** The Consortia may, at its discretion, remove any officer upon a majority of the votes cast at a duly called meeting where a quorum is present.

## ARTICLE EIGHT – Florida HIV/AIDS Comprehensive Planning Network (FCPN) Representation

The Consortium will be represented at the Florida HIV/AIDS Comprehensive Planning Network (FCPN).

1. One representative and alternate will each be a Consortium voting member with interest/expertise in HIV Patient Care. A letter of recommendation for this member and alternate will be prepared by the Chair of the Consortium, based on their nomination by the Consortium.
2. One representative and alternate will each be a Consortium voting member with interest/expertise in HIV Prevention. A letter of recommendation for this member and alternate will be prepared by the Chair of Consortia, based on their nomination by the Consortium.
3. The Consortium may also nominate "At Large" representative(s) who are Consortium voting members with interest/expertise in other areas as defined in the FCPN guidance. A letter of recommendation for this (these) member(s) will be prepared by the Chair of Consortium, based on their nomination by the Consortium.

Each of the FCPN representatives and alternates that are recommended by the Consortium and accepted by the Bureau of HIV/AIDS as a representative or an alternate must be an active voting member of Consortium throughout their FCPN term and report on the activities of FCPN at the regular Consortium meetings.

## ARTICLE NINE – Books and Records

The Lead Agency will keep minutes of all proceedings of the Consortium and other books and records as may be required for the proper conduct of its business and affairs. Voting records will be maintained at the Administrative office and be open to the public for review.

## ARTICLE TEN – Amendments

Written notice of proposed bylaws changes will be mailed and/or electronically delivered to all active voting members to consider for at least 10 days prior to the date of the meeting in which a vote will be taken.

Amendments require a majority vote of the active voting members present at a duly called meeting with a quorum.

## ARTICLE ELEVEN – Dissolution

The Consortium may be dissolved by its voting membership upon acceptance of a resolution of dissolution by a two-thirds (2/3) majority vote of the voting members present at a duly called meeting with a quorum.

## ATTACHMENTS

1. Code of Conduct
2. Job Descriptions
3. Grievance Procedure
4. Grievance Form
5. Conflict of Interest and Disclosure Form
6. Membership Application
7. Glossary of Terms

**Northwest Florida AIDS Consortium**
**(NoFLAC)**

## Code of Conduct

- Behave in a manner that reflects their responsibility to represent the group.
- Hold in confidence information presented in confidence.
- Address comments to the Chair.
- Declare when an issue being discussed may benefit themselves, their employer or a family member/significant other. Issues that will potentially benefit all PLWHA in the service area do not have to be declared by a member who is a PLWHA or a member who has a family member/significant other who is a PLWHA, provided there is no additional potential benefit to the member or family member/significant other than would benefit any other PLWHA in the service area who is not a member of the group.
- Accept and support the decisions made by the group according to the prescribed method(s) of decision-making.
- Take positive responsibility for helping to prevent and resolve conflicts within the group.
- All members will be given a chance to speak once on each issue before recognizing a member who has already spoken on the issue. This does not apply to Points of Order or Points of Information (questions) or the member of whom the Chair requests an answer.
- Take responsibility for following this Code of Conduct as well as speaking out to ensure other members abide by this Code of Conduct.
- Agree that a civil atmosphere should prevail at each meeting.
- Do not interrupt people when they are speaking.
- Show respect to other members of the community group.
- Identify yourself prior to speaking so that the tape can pick up who is speaking.
- Ask to be indentified by the Chairperson prior to speaking.
- Avoid side conversations with other members during the meeting.
- Be on time for meetings.
- Speak for yourself and do not claim to speak for others.
- Be polite. It's acceptable to disagree, but do so respectfully.
- Agree that insults and accusations are unacceptable.
- Turn all pagers and cell phones off or to the "vibrate" position.
- Leave personal agendas/attitudes/hidden agenda/ego at the door.
- Be respectful of cultural differences.
- Observe confidentiality within established policies.
- Be open to listening to and learning from other's viewpoints.
- Observe conflict of interest policies and declare when an issue being discussed may benefit you, your agency, or a family member.

## NoFLAC Job Descriptions

### Job Title: Consortium Member

Reports To: Consortium

Minimum qualifications: Ability to lead; administrative capability; ability to communicate in both written and verbal formats; willingness to serve and must be a voting member in good standing.

Duties and Responsibilities:

- Attend regular meetings and actively participate on at least one committee.
- Read the minutes from the previous meeting and meeting packet material prior to each meeting.
- Bring all materials sent to you by the Lead Agency to the meeting.
- Work with others to develop a comprehensive array of HIV/AIDS service, including prevention, early intervention, and patient care.
- Serve as a knowledgeable person with information about HIV/AIDS services: not as an "agency representative" (Leave "turf issues" at the door).
- Declare all potential conflicts of interest.
- Recruit members to the Consortium.

### Job Title: Chair

Reports to: Steering Committee and the Consortium

Minimum qualifications: Ability to lead; administrative capability; ability to communicate in both written and verbal formats; willingness to serve and must be a voting member in good standing.

Duties and Responsibilities:

- Facilitate meeting of the Consortium and Steering Committee.
- Serve as Ex-Officio member of all other committees.
- Foster an environment of collaboration and cooperation.
- Represent the Consortium to other organizations and institutions.
- Guide the Consortium through patient care planning processes.
- Work with the Lead Agency to coordinate the delivery of all required documents.

### Job Title: Vice-Chair

Reports to: Chair, Steering Committee and Consortium

Minimum Qualifications: Ability to lead, administrative capability, ability to communicate in both written and verbal formats, willingness to serve. The Vice-Chair must be a voting member in good standing.

Duties and Responsibilities:

- Facilitate meeting of the Consortium and Steering Committee in the absence of the Chair.
- Serve as Ex-Officio member of all other committees, attending as many as practical.
- Foster an environment of collaboration and cooperation.
- Represent the Consortium to other organizations and institutions.
- Assist the Chair in guiding the Consortium through prevention, early intervention, and patient care planning processes.
- Assist the Chair in coordinating with the Lead Agency in the delivery of all required documents in a timely manner.
- Assume the position of Chair in the event of resignation or removal of the Chair.

### Job Title: Nominating Committee Member

Reports to: Nominating Committee Chair & Consortium

Minimum Qualifications: Nominating Committee members are comprised of active members and are committed to participating impartially to present a slate of officers to the Consortium.

Duties and Responsibilities:

- Convene a minimum of two times annually.
- Determine eligibility of members based upon the by-laws.
- Accept nominations from the Consortium.
- Confirm acceptance of the nominees.
- Present the slate of candidates to the Consortium for a vote.

## NoFLAC Grievance Resolution Process Instructions

**GRIEVANCE DEFINITION:**

- Member grievances should be confined to the Consortium's areas of responsibility.
- Grievances about service providers' performance, clients' complaints, problems with state or local health departments and other matters outside the auspices of the Consortium should be pursued elsewhere.
- Informal methods to resolve differences should be explored prior to initiating a formal complaint.

**STEP 1:**
The Grievant is to present the grievance in writing (using the grievance form) to the Consortium Chair immediately upon becoming aware of the act or condition that is the basis for the grievance, but no later than 30 days.

**STEP 2:**
The Consortium Chair will respond in writing to the Grievant within seven working days from the date of receipt by the lead agency. The Consortium Chair's reply will state the actions to be taken to resolve the grievance, or outline in detail the reasons why the Consortium Chair is unable to resolve the grievance to the Grievant's satisfaction.

**STEP 3:**

**PART A:** If the grievance is not resolved in Step Two, the Grievant may (within seven working days from the date of the Consortium Chair's reply) request Steering Committee review by completing Step Three of the grievance form and returning the original grievance and all the responses to the Steering Committee Chair.

**PART B:** The Steering Chairperson will schedule a meeting of the Steering Committee within 10 working days to review the grievance. The Steering Committee will render a written response within 3 working days of the called meeting.

**PART C:** The Steering Committee may, at their discretion, request an Ad-hoc Committee be formed in circumstances where they feel further review is necessary. The Ad-ho Committee would then complete this step in lieu of the Steering Committee.

The Steering Committee or Ad-hoc Committee's response is final and not subject to further review.

**REPORTING**
Copies of the Grievance form will be distributed as appropriate during the resolution process to Grievant, Consortium Chairpersons, the Steering Committee members and the lead agency. Original copies will be kept by the lead agency and are the sole property of the Consortium.

**Northwest Florida AIDS Consortium**
**Grievance Form**

**Step 1 – Consortium Grievance**

**GRIEVANT INFORMATION: (To be completed by Grievant)**

Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

**GRIEVANCE: (To be completed by Grievant)**

**INSTRUCTIONS:** The Grievant is to present the grievance in writing using the grievance form to the Consortium Chairperson immediately upon becoming aware of the act or condition that is the basis for the grievance, but no later than 30 days.

_____

**My grievance is as follows:**

**My proposed solution is as follows:**



Date Approved: July 13, 2009
Last Amended: April 21, 2016

_____ _____

Grievant's Signature Date

**Northwest Florida AIDS Consortium**

**Copies of the Grievance form will be distributed as appropriate during the resolution process to: Grievant, Consortium Chair, and to the Steering Committee members. Original copies will be kept by the Lead Agency and are the sole property of the Consortium.**

**STEP 2 – Consortium Chairperson Reply** (To be completed by the Consortium Chairperson)

**INSTRUCTIONS:** The Consortium Chairperson will respond in writing to the Grievant within seven working days from the date of receipt by the lead agency. The Consortium Chairperson's reply will state the actions to be taken to resolve the grievance, or outline in detail the reasons why the Consortium Chairperson is unable to resolve the grievance to the Grievant's satisfaction.

_____

**The Consortium Chairperson's reply to grievance, state the action(s) to be taken to resolve the grievance or outlining why the grievance cannot be satisfied:**

Signed: _____ Date: _____

(If more space is needed, use additional sheets and attach)

**Copies of the Grievance form will be distributed as appropriate during the resolution process to Grievant, Consortium Chairperson, and the Steering Committee members. Original copies will be filed by the Lead Agency and are the sole property of the Consortium.**

**Northwest Florida AIDS Consortium**

**STEP 3 – Part A – Request for Steering Committee Review (**To be completed by Grievant)

**INSTRUCTIONS:** If the grievance is not resolved in Step One, the Grievant may, within seven working days from the date of the Consortium Chairperson's reply, request Steering Committee review by completing section two of the grievance form, and returning the original grievance and all the responses to the Steering Committee Chairperson addressed to the Consortium.

I have reviewed the Consortium Chairperson's reply to my grievance and the grievance has not been resolved to my satisfaction. I request a review by the Steering Committee.

_____ _____

Grievant's Signature Date

**Grievant must attach original grievance and the Consortium Chairperson's reply.**

**STEP 3 – PART B – Steering Committee Review Meeting Scheduled**

**INSTRUCTIONS:** The Steering Chairperson will schedule a meeting of the Steering Committee at the earliest time, within 10 working days, to review the grievance. The Steering Committee will render a written response within 3 working days of the called meeting. The Steering Committee may, at their discretion, request an Ad-hoc Committee be formed in circumstances where they feel further review is necessary. The Ad-hoc Committee would then complete this step in lieu of the Steering Committee.

_____

**Steering Committee's reply to grievance, stating the action(s) to be taken to resolve the grievance or outlining why the grievance cannot be satisfied:**

Signed: _____ Date: _____
(If more space is needed, use additional sheets and attach)

**Northwest Florida AIDS Consortium**

**STEP 3 – PART C – Steering or Ad-Hoc Committee Final Reply**

**NOTE: The Steering or Ad-Hoc Committee's response is final and not subject to further review.**

_____

**Steering or Ad-Hoc Committee's Final reply to the grievance stating the action(s) to be taken to resolve the grievance:**

Signed: _____ Date: _____
(If more space is needed, use additional sheets and attach)

**Copies of the Grievance form will be distributed as appropriate during the resolution process to Grievant, the Consortium Chairperson, the Steering and the Ad-Hoc Committee members. Original copies will be filed by the Lead Agency and are the sole property of the Consortium.**

**Northwest Florida AIDS Consortium**

***Conflict of Interest Disclosure***

**The Northwest Florida AIDS Consortium (NoFLAC) has members who are professionally or personally affiliated with organizations that have, or might in the future request or receive funds for HIV/AIDS prevention or patient care activities or services. Because of this potential conflict of interest, this disclosure form has been adopted and approved by the Consortium and approved by the Florida Health Department, Bureau of HIV/AIDS and must be completed by all current members in accordance with the Consortium bylaws.**

**By my signature below, I certify that I have read, understand and support the Consortium's bylaws and have received, read understand and support the Conflict of Interest Policy and Procedures statement. Listed below are the organizations with which I am presently affiliated.**

**Organization:** _____

**Title:** _____ **Period of Affiliation:** _____

**Organization:** _____

**Title:** _____ **Period of Affiliation:** _____

**Organization:** _____

**Title:** _____ **Period of Affiliation:** _____

**Organization:** _____

**Title:** _____ **Period of Affiliation:** _____

**Please attach additional pages if necessary.**

**The following is true to the best of my knowledge and ability:**

**Neither I nor my immediate family has received or intends to receive any gratuities, favors, or anything of material value by a representative of a community-based organization that might alter my ability to work objectively in the Consortium's planning process.**

**Consortium Member Name (please print):** _____

**Member signature:** _____

**Date:** _____

**NORTHWEST FLORIDA AIDS CONSORTIUM (NoFLAC)**
**MEMBERSHIP APPLICATION/AGREEMENT**

It is the policy of NoFLAC to appoint and retain persons from all represented service areas, infected and affected population groups and various fields of expertise, including people who have an active interest in the care of persons living with AIDS and HIV. Members agree to (a) participate in the planning, implementation and evaluation of a comprehensive service plan for people living with AIDS; (b) to participate actively on at least one Consortium committee; (c) assist in providing information, referral, advocacy, support and education regarding HIV and AIDS and NoFLAC's mission.

**PLEASE PRINT**

NAME: _____

MAILING ADDRESS: _____

CITY, STATE, ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

FAX LINE: _____ EMAIL ADDRESS: _____

EMPLOYER: _____

OCCUPATION: _____

For the purpose of ensuring a membership that reflects the economic, social, racial, ethnic, sexual orientation and gender composition of the population being served, the following information is requested, *BUT NOT REQUIRED***.**

County of Residence: Escambia_____ Santa Rosa_____ Okaloosa_____ Walton_____

Other – Please Specify: _____

Date of Birth: _____ Gender (M/F): _____ Transgendered (Y/N):_____

Race: White _____ Black _____ Asian _____ American Indian _____ Hawaiian/PI _____

Other or Mixed Race – Please Specify: _____

Ethnicity: Hispanic _____ Not Hispanic or Latino _____ Other _____

**OPTIONAL INFORMATION:** Living with HIV/AIDS (Y/N): _____

Caregiver of family member of person living with HIV/AIDS (Y/N): _____

Sexual Orientation: Straight _____ Gay or Lesbian ____ Bisexual _____

**PLEASE CONTINUE ON REVERSE**

**Please indicate your representation: CHECK ALL THAT APPLY**

____ AIDS Service Organization
____ Business Group
____ Caregiver to Person Living with AIDS
____ Community Based Organization
____ Criminal Justice Services
____ Educational Institution
____ Elder Population
____ Elected Government Official
____ Family Member of Person Living w/ AIDS
____ Financial Institution
____ Gay & Lesbian Organization
____ Home Health Agency
____ Hospice Organization
____ Hospital
____ Housing provider
____ Media
____ Medical, Public Health & Social Svc Society
____ Mental Health Agency
____ Minority Organization
____ Person Living w/ AIDS
____ Department of Health
____ Religious Organization
____ Substance Abuse Treatment Provider
____ Support Group Organization
____ Women's Services
____ Youth Service Organization

**Please indicate your preference of Committee Membership (*sign up for at least one*).**

Primary Standing Committees

_____ Needs and Resources _____ Standards and Quality

Secondary Committees

_____ Priorities and Allocations _____ Nominating Committee

Signature: _____ Date: _____

**FOR CONSORTIUM MEMBERSHIP COMMITTEE USE ONLY:**

MEMBERSHIP CATEGORY: ____ CONSUMER



Date Approved: July 13, 2009
Last Amended: April 21, 2016

____ INDIVIDUAL
____ ORGANIZATIONAL
____ EX-OFFICIO

# Appendix A:

**Glossary of Care Act Terms**

**ADAP (AIDS Drug Assistance Program)**

Administered by States and authorized under Title II of the CARE Act, provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured CARE Act clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.

**Administrative or Fiscal Agent**

Entity that functions to assist the grantee, consortium, or other planning body in carrying out administrative activities (*e.g.*, disbursing program funds, developing reimbursement and accounting systems, developing Requests for Proposals [RFPs], monitoring contracts).

**AETC (AIDS Education and Training Center)**

Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the CARE Act and administered by the HRSA HIV/AIDS Bureau's Division of Training and Technical Assistance (DTTA).

**AIDS (Acquired Immunodeficiency Syndrome)**

A group of life-threatening diseases caused by the human immunodeficiency virus.

**Antiretroviral**

A substance that fights against a retrovirus, such as HIV. (See Retrovirus)

**ASO (AIDS service organization)**

An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.

**Capacity**

Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development activities should increase access to the HIV/AIDS service system and reduce disparities in care among underserved PLWH in the EMA.

**CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act)**

Federal legislation created to address the unmet health care and service needs of people living with HIV Disease (PLWH) disease and their families. It was enacted in 1990 and reauthorized in 1996 and 2000.

**CADR (CARE Act Data Report)**

A provider-based report generating aggregate client, provider, and service data for all CARE Act programs. Reports information on all clients who receive at least one service during the reporting period. Replaces the Annual Administrative Report (AAR) used for Title I and Title II as well as separate Title III and Title IV data reports.

**CBO (community-based organization)**

An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

**CDC (Centers for Disease Control and Prevention)**

Federal agency within HHS that administers disease prevention programs including HIV/AIDS prevention.

**CD4 or CD4+ Cells**

Also known as "helper" T-cells, these cells are responsible for coordinating much of the immune response. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.

**CD4 Cell Count**

The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal adult range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. (The normal range for infants is considerably higher and slowly declines to adult values by age 6 years.) CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm3. If the count is lower, testing every 3 months is advised. (In children with HIV infection, CD4 values should be checked every 3 months.) A CD4 count of 200 or less is an AIDS-defining condition.

**Co-morbidity**

A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

**Community Forum or Public Meeting**

A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (*i.e.*, not randomly selected to attend).

**Comprehensive Planning**

The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PLWH.

**Consortium/HIV Care Consortium**

A regional or statewide planning entity established by many State grantees under Title II of the CARE Act to plan and sometimes administer Title II services. An association of health care and support service agencies serving PLWH under Title II of the CARE Act.

**Continuous Quality Improvement**

An ongoing process that involves organization members in monitoring and evaluating programs to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care by identifying opportunities for improvement.

**Continuum of Care**

An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH.

**Cultural Competence**

The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

**Early Intervention Services (EIS)**

Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Titles I and II of the CARE Act, includes outreach, counseling and testing, information and referral services. Under Title III of the CARE Act, also includes comprehensive primary medical care for individuals living with HIV/AIDS.

**Eligible Metropolitan Area (EMA)**

Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Title I CARE Act funds.

**EIA (Enzyme-Linked Immunosorbent Assay)**

The most common test used to detect the presence of HIV antibodies in the blood, which indicate ongoing HIV infection. A positive ELISA test result must be confirmed by another test called a Western Blot.

**Epidemic**

A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

**Epidemiologic Profile**

A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.

**Epidemiology**

The branch of medical science that studies the incidence, distribution, and control of disease in a population.

**Ex-Officio Member**

Member generally taken to be a person, who, by virtue of an office or position held, is officially attached to a committee as a non voting member. A person who is granted status as a member of a group by virtue of their specific power or authority. Ex: “The Vice-President is the ex-officio President of the Senate.”

**Genotypic Assay**

A test that analyzes a sample of the HIV virus from the patient’s blood to identify actual mutations in the virus that are associated with resistance to specific drugs.

**Grantee**

The recipient of CARE Act funds responsible for administering the award.

**HAART (Highly Active Antiretroviral Therapy)**

HIV treatment using multiple antiretroviral drugs to reduce viral load to undetectable levels and maintain/increase CD4 levels.

**Health Insurance Continuity Program (HICP) (AIDS Insurance Continuation, AICP in Florida)**

A program primarily under Title II of the CARE Act that makes premium payments, co-payments, deductibles, and/or risk pool payments on behalf of a client to purchase/maintain health insurance coverage.

**HIV/AIDS Bureau (HAB)**

The bureau within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White CARE Act.

**HIV/AIDS Dental Reimbursement Program**

The program within the HRSA HIV/AIDS Bureau’s Division of Community Based Programs that assists with uncompensated costs incurred in providing oral health treatment to PLWH.

**HIV Disease**

Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

**Home and Community Based Care**

A category of eligible services that States may fund under Title II of the CARE Act.

**HOPWA (Housing Opportunities for People With AIDS)**

A program administered by the U.S. Department of Housing and Urban Development (HUD) that provides funding to support housing for PLWH and their families.

**HRSA (Health Resources and Services Administration)**

The agency of the U.S. Department of Health and Human Services that administers various primary care

programs for the medically underserved, including the Ryan White CARE Act.

**HUD (U.S. Department of Housing and Urban Development)**

The Federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for People with AIDS (HOPWA).

**Incidence**

The number of new cases of a disease that occur during a specified time period.

**Incidence Rate**

The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 persons. AIDS incidence rates are often expressed this way.

**Lead Agency**

The agency within a Title II consortium that is responsible for contract administration; also called a fiscal agent (an incorporated consortium sometimes serves as the lead agency)

**Medicaid Spend-down**

A process whereby an individual who meets the Medicaid medical eligibility criteria, but has income that exceeds the financial eligibility ceiling, may "spend down" to eligibility level. The individual accomplishes spend-down by deducting accrued medically related expenses from countable income. Most State Medicaid programs offer an optional category of eligibility, the "medically needy" eligibility category, for these individuals.

**MAI (Minority AIDS Initiative)**

A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. Enacted to address the disproportionate impact of the disease in such communities. Formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

**Multiply Diagnosed**

A person having multiple morbidities (*e.g.*, substance abuse and HIV infection) (see co-morbidity).

**Needs Assessment**

A process of collecting information about the needs of PLWH (both those receiving care and those not in care), identifying current resources (CARE Act and other) available to meet those needs, and determining what gaps in care exist.

**NNRTI (Non-Nucleoside Reverse Transcriptase Inhibitor, called "non-nuke")**

A class of antiretroviral agents (*e.g.*, delavirdine, nevirapine, efavirenz) that stops HIV production by binding directly onto an enzyme (reverse transcriptase) in a CD4+ cell and preventing the conversion of HIV's RNA to DNA.

**Nucleoside Analog (Nucleoside Analog Reverse Transcriptase Inhibitor, NRTI, called "nuke")**

The first effective class of antiviral drugs (*e.g.*, AZT or ZDV, ddI, ddC, d4T, ABC). NRTIs act by incorporating themselves into the HIV DNA, thereby stopping the building process. The resulting HIV DNA is incomplete and unable to create new virus.

**OMB (Office of Management and Budget)**

The office within the executive branch of the Federal government that prepares the President's annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

**Opportunistic Infection (OI) or Opportunistic Condition**

An infection or cancer that occurs in persons with weak immune systems due to HIV, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus (CMV) are all examples of opportunistic infections.

**Part F**

The part of the CARE Act that includes the AETC Program, the SPNS Program, and the HIV/ AIDS Dental Reimbursement Program.

**PCR (Polymerase Chain Reaction)**

A laboratory process that selects a DNA segment from a mixture of DNA chains and rapidly replicates it to create a sample of a piece of DNA. For HIV, this is called RT-PCR, which is a laboratory technique that can detect and quantify the amount of HIV (viral load) in a person's blood or lymph nodes. PCR is also used for the diagnosis of HIV infection in exposed infants.

**Phenotypic Assay**

A procedure whereby sample DNA of a patient's HIV is tested against various antiretroviral drugs to see if the virus is susceptible or resistant to these drug(s).

**PHS (Public Health Service)**

An administrative entity of the U.S. Department of Health and Human Services.

**Planning Process**

Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

**PLWHA (People Living with HIV Disease and AIDS)**

Term used to refer to persons living with HIV Disease and AIDS.

**Prevalence**

The total number of persons in a defined population living with a specific disease or condition at a given time (compared to incidence, which is the number of new cases).

**Prevalence Rate**

The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

**Priority Setting**

The process used to establish priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.

**Prophylaxis**

Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has previously been brought under control (secondary prophylaxis).

**Protease**

An enzyme that triggers the breakdown of proteins. HIV's protease enzyme breaks apart long strands of viral protein into separate proteins constituting the viral core and the enzymes it contains. HIV protease acts as new virus particles are budding off a cell membrane.

**Protease Inhibitor**

A drug that binds to and blocks HIV protease from working, thus preventing the production of new functional viral particles.

**Quality**

The degree to which a health or social service meets or exceeds established professional standards and user expectations.

**QA (Quality Assurance)**

The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

**QI (Quality Improvement)**

Also called Continuous Quality Improvement (CQI). An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care.

**Reflectiveness**

The extent to which the demographics of the planning body's membership look like the demographics of the epidemic in the service area.

**Reliability**

The consistency of a measure or question in obtaining very similar or identical results when used repeatedly; for example, if you repeated a blood test three times on the same blood sample, it would be reliable if it generated the same results each time.

**Representative**

Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

**RFP (Request for Proposals)**

An open and competitive process for selecting providers of services (sometimes called RFA or Request for Application).

**Resource Allocation**

The Title I planning council responsibility to assign CARE Act amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

**Retrovirus**

A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.

**Reverse Transcriptase**

A uniquely viral enzyme that constructs DNA from an RNA template, which is an essential step in the life cycle of a retrovirus such as HIV. The RNA-based genes of HIV and other retroviruses must be converted to DNA if they are to integrate into the cellular genome. (See Retrovirus.)

**Risk Factor or Risk Behavior**

Behavior or other factor that places a person at risk for disease; for HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.

**RT-PCR (Reverse Transcriptase Polymerase Chain Reaction)**

A laboratory technique that can detect and quantify the amount of HIV (viral load) in a person's blood or lymph nodes.

**Salvage Therapy**

A treatment effort for people who are not responding to, or cannot tolerate the preferred, recommended treatments for a particular condition. In the context of HIV infection, drug treatments that are used or studied in individuals who have failed one or more HIV drug regimens. In this case, failed refers to the inability to achieve or sustain low viral load levels.

**SAMHSA (Substance Abuse and Mental Health Services Administration)**

Federal agency within HHS that administers programs in substance abuse and mental health.

**SCSN (Statewide Coordinated Statement of Need)**

A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination. The SCSN process is convened by the Title II grantee, with equal responsibility and input by all programs.

**Section 340B Drug Discount Program**

A program administered by the HRSA's Bureau of Primary Care, Office of Pharmacy Affairs established by Section 340B of the Veteran's Health Care Act of 1992, which limits the cost of drugs to Federal purchasers and to certain grantees of Federal agencies.

**Seroconversion**

The development of detectable antibodies to HIV in the blood as a result of infection. It normally takes several weeks to several months for antibodies to the virus to develop after HIV transmission. When antibodies to HIV appear in the blood, a person will test positive in the standard ELISA test for HIV.

**Seroprevalence**

The number of persons in a defined population who test HIV-positive based on HIV testing of blood specimens. (Seroprevalence is often presented either as a percent of the total specimens tested or as a rate per 100,000 persons tested.)

**Service Gaps**

All the service needs of all PLWH except for the need for primary health care for individuals who know their status but are not in care. Service gaps include additional need for primary health care for those already receiving primary medical care ("in care").

**SPNS (Special Projects of National Significance)**

A health services demonstration, research, and evaluation program funded under Part F of the CARE Act to identify innovative models of HIV care. SPNS projects are awarded competitively.

**STD (Sexually Transmitted Disease)**

**Surveillance**

An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases (*e.g.*, Centers for Disease Control and Prevention surveillance system for AIDS cases).

**Surveillance Report**

A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific sub-populations.

**TA (Technical Assistance)**

The delivery of practical program and technical support to the CARE Act community. TA is to assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating CARE Act-supported planning and primary care service delivery systems.

**Target Population**

A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

**Part A**

The part of the CARE Act that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV/AIDS epidemic.

**Part B**

The part of the CARE Act that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PLWH and their families.

**Part C**

The part of the CARE Act that supports outpatient primary medical care and early intervention services to PLWH through grants to public and private non-profit organizations. Title III also funds capacity development and planning grants to prepare programs to provide EIS services.

**Part D**

The part of the CARE Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their families.

**Transmission Category**

A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include, for example, men who have sex with men (MSM), injection drug use (IDU), heterosexual contact, and perinatal transmission.

**Unmet Need**

The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care.

**Viral Load**

In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.

**Viremia**

The presence of virus in blood or blood plasma. Plasma viremia is a quantitative measurement of HIV levels similar to viral load but is accomplished by seeing how much of a patient's plasma is required to spark an HIV infection in a laboratory cell culture.

**Western Blot**

A test for detecting the specific antibodies to HIV in a person's blood. It is commonly used to verify positive EIA tests. A Western Blot test is more reliable than the EIA, but it is more difficult and more costly to perform. All positive HIV antibody tests should be confirmed with a Western Blot test.

**Wild Type Virus**

HIV that has not been exposed to antiviral drugs and therefore has not accumulated mutations conferring drug resistance.