Willamette Valley Community Health

Community Advisory Council Membership Application Form

The Community Advisory Council (CAC) is chartered by the Willamette Valley Community Health (WVCH) governing body to advise and make recommendations on the strategic direction of the organization. The CAC will help WVCH remain responsive to consumer and community health needs. The CAC is intended to enable consumers, which will comprise a majority of the CAC, to take an active role in improving their own health and the health of their family and community members.

All interested in applying for the WVCH Community Advisory Council should complete this form and return it to:

Stuart Bradley
WVP Health Authority, Suite 200
2995 Ryan Drive SE, Salem, OR 97301
Fax: 503-485-3224
E-mail: sbradley@mvipa.org

The information on this application will be kept confidential, only members of the Selection Committee will see this information

Please type or print clearly.

_____
First Name Middle Initial Last Name

_____
Organization/Employer (If Applicable)

_____
Telephone E-mail Address

_____
Physical Address

_____
City Zip County

What is your preferred method of communication? (check one)

Telephone _____ When is the best time to call? _____
E-mail _____
Mail _____

1) Please tell us about yourself. Please write about your background and participation in other community forums, public planning processes, advisory councils, etc. Attach more pages if needed.

_____
_____
_____
_____
_____
_____

The Community Advisory Council's main responsibility is to provide recommendations to the governing body and/or Clinical Advisory Panel on the following:

- Community Health Assessment
- Preventive care practices
- Community Health Improvement Plan
- Policy guidelines on consumer related activities of WVCH

The Community Advisory Council's recommendations are non-binding. If CAC recommendations are not prioritized, the governing body will provide feedback to the committee.

2) Please tell us why you want to be on this council. What will your background or interests offer to the team? Limit to one to two paragraphs please.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

3) Are you currently a member of other Medicaid or advocacy committees or councils?
No Yes

If you circled *yes*, please list which committees or councils you are a member of.

_____
_____
_____
_____
_____

4) What is your experience with being an Oregon Health Plan Member or family of a member?

___None
___Less than 1 year
___1-2 years
___3-5 years
___More than 5 years
___More than 10 years

5) What is your membership category? (check all that apply):

___Member – you are currently enrolled in Medicaid (Oregon Health Plan)
___Family member or legal guardian of a Medicaid member (OHP)
___Community Leader
___Community organization (name of community organization _____)

6) What is your date of birth? (optional) _____

7) What is your gender? (optional) _____

8) What is your race/ethnicity? (optional):

___ American Indian/Alaska Native
___ Asian/Pacific Islander
___ Black
___ Hispanic
___ White
___ Other _____

9) What time can you attend meetings?

What days of the week work best for you? _____

What time works best for you?

_____ Mornings only between _____am & _____am
_____ Afternoons only between _____pm & _____pm
_____ Evenings only between _____pm & _____pm

10) We can provide a stipend to consumer members for these meetings and other accommodations such as language interpretation. Do you need interpretation or any special accommodations? If so, what?

_____
_____
_____

References

Please list two or three people below who can tell us about what you would contribute to the Community Advisory Council.

_____

First Name Last Name

_____

Organization/Employer (If Applicable)

_____

Relationship to you

_____

Telephone E-mail Address

_____

First Name Last Name

_____

Organization/Employer (If Applicable)

_____

Relationship to you

_____

Telephone E-mail Address

_____

First Name Last Name

_____

Organization/Employer (If Applicable)

_____

Relationship to you

_____

Telephone E-mail Address

I certify that the statements made by me on this form are true and correct to the best of my knowledge and belief. I agree to serve on the Willamette Valley Community Health Community Advisory Council for three years. I will attend and participate in at least 75% of the meetings per year. If I am unable to attend, I will notify the WVCH CAC Chairperson or Vice Chairperson prior to the meeting.

_____

Signature of Applicant Date

Completion of this form does not automatically make someone a council member. The WVCH CAC Selection Committee will choose members based on geographic diversity and representation of other Medicaid members.

If you are not selected for the CAC, may we contact you to participate in other WVCH activities in the future? _____Yes _____No