

- 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