Central Oregon Health – Provider Engagement Panel Membership Application Form

The Provider Engagement Panel (PEP) is chartered by the Central Oregon Health Council (COHC) Board of Directors to advise and make recommendations to it on the strategic direction of the organization. The PEP will review and establish clinical and utilization standards for care for the Central Oregon regional Coordinated Care Organization. The PEP is intended to be a multi-disciplinary forum for discussion and decision-making regarding the clinical care of patients served by the CCO.

All interested in applying for the COHC Provider Engagement Panel should complete this form and return it to:

Central Oregon Health Council
PO Box 6689
Bend, OR 97708
E-mail: info@cohealthcouncil.org

PLEASE TYPE OR PRINT CLEARLY.

_____
FIRST NAME MI LAST NAME DEGREE

_____
ORGANIZATION/EMPLOYER (IF APPLICABLE)

_____
CLINICAL AREA OF EXPERTISE

_____
TELEPHONE EMAIL ADDRESS

_____
PHYSICAL ADDRESS

_____
CITY ZIP COUNTY

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.

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

3) Are you currently a member of other Medicaid or advocacy committees or councils?

☐ No ☐ Yes

If yes, please list: Attach more pages if needed.

4) References: Please list two or three people below who can tell us about what you would contribute to the PEP

FIRST NAME MI LAST NAME

ORGANIZATION/EMPLOYER (IF APPLICABLE)

TELEPHONE EMAIL ADDRESS

FIRST NAME MI LAST NAME

ORGANIZATION/EMPLOYER (IF APPLICABLE)

TELEPHONE EMAIL ADDRESS

FIRST NAME MI LAST NAME

ORGANIZATION/EMPLOYER (IF APPLICABLE)

TELEPHONE EMAIL ADDRESS

Race/ethnicity (optional):

___American Indiana/Alaska Native
___Asian/Pacific Islander
___Black
___Hispanic
___White
___Other

The percentage of your current patient panel that is enrolled in the Oregon Health Plan is?

___None
___>25% practice
___25-50% practice
___50-75% practice
___75% +

Meeting Preference?
_____Early morning (before 8 am)
_____Lunch hour
_____After 5 pm

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 COHC Provider Engagement Panel for two years. I will attend and participate in at least four meetings a year and any other sub-committee meetings as needed. If I am unable to attend, I will notify the COHC staff prior to the meeting.

_____

SIGNATURE OF APPLICANT DATE

Completion of this form does not make someone a council member. COHC will choose members based on geographic diversity and representation of clinical expertise.

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