Central Oregon Health Council Community Advisory Council Membership Application Form

The Community Advisory Council (CAC) 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 CAC will help the COHC 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 that of their family and community members.

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

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

PLEASE TYPE OR PRINT CLEARLY.

_____
FIRST NAME MI LAST NAME

_____
ORGANIZATION/EMPLOYER (IF APPLICABLE)

_____
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 council. 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 (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 CAC

_____
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

Experience with being an Oregon Health Plan Member?

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

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

___You have been enrolled in Medicaid (Oregon Health Plan) within the last two years.
___You have been a legal guardian of a Medicaid member (OHP) within the last two years.
___Community Leader
___Community organization (name of community organization)_____

Can you attend daytime meetings?

_____Yes – any time
_____Yes – morning only
_____Yes – afternoon only
_____No

We can provide transportation to these meetings and other accommodations such as language interpretation. Do you need transportation, interpretation or any special accommodations? If so, what?

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 Community Advisory Council 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 other Medicaid members.

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