

**Community Advisory Council (CAC)**

**Application Form**

Welcome to the Central Oregon Health Council (COHC) Community Advisory Council (CAC).

We want to hear about health care from people on PacificSource Community Solutions Oregon Health Plan (PSCS OHP) like you. We need your advice about health needs in our area and how to make health care and services better.

We are so excited that you want to help! Please complete this form so we can get to know you better. The information you share will help us know how we can start working together.

When you finish this form, please send it to:

Central Oregon Health Council

PO Box 6689

Bend, OR 97708

E-mail: [macayla.arsenault@cohealthcouncil.org](mailto:macayla.arsenault@cohealthcouncil.org)

After we get your application, it will be reviewed by a few Community Advisory Council (CAC) members. After they review your application we will call or email you and talk to you about what happens next.

**BASIC INFORMATION:**

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_

Legal First Name Middle Initial Legal Last Name

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Email Address

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City Zip County

\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (dd/mm/yyyy)

The Oregon Health Authority gives us some rules to help us do a great job improving health in our region.

The rules say that most of the people on the Community Advisory Committee (CAC) must be on PacificSource Community Solutions (PSCS OHP) or be the legal guardian of someone on PacificSource Community Solutions (PSCS OHP).

Please answer the next two questions to help us understand your experience with PacificSource Community Solutions (PSCS OHP).

1. Please put a check mark next to the statements that apply to you:

I am currently enrolled in PacificSource Community Solutions (PSCS OHP)

The top of your health insurance card will say “PacificSource Community Solutions”

I am the parent or legal guardian of someone enrolled in PacificSource Community Solutions (PSCS OHP)\*

*\*If you checked this box, please complete the Dependent Information Form for each dependent you represent*

I am enrolled in one of these:

The top of your health insurance card will say “Oregon Health ID or DHS Medical Care ID”

* Oregon Health Plan (OHP) DMAP
* Oregon Health Plan (OHP) Medicaid
* Oregon Health Plan (OHP) Open Card
* Oregon Health Plan (OHP) Fee-for-Service

I am from a community organization

The name of my organization is:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Not sure which insurance plan you’re part of? Give our office a call and we can help: 541-306-3523.

1. How long have you been on PacificSource Community Solutions (PSCS OHP)?

Not at all

Less than 1 year

1-2 years

3-5 years

More than 5 years

More than 10 years

**INTEREST IN THE COMMUNITY ADVISORY COUNCIL (CAC)**

Please answer the questions below. If you don’t have enough space here, please add more pages.

1. Tell us a little about yourself. Share about your life, family, and interests.

1. Why do you want to be part of the Community Advisory Council (CAC)?

1. What do you hope to get from being part of the Community Advisory Council (CAC)?

1. What do you hope to bring to the Community Advisory Council (CAC)?

1. Have you been part of a community group before? What were they? What did you do?

**RACE, ETHNICITY, LANGUAGE, AND DISABILITY**

We not discriminate on the basis of geography, race, national origin, ethnicity, culture, language spoken, diverse-ability, age, faith, gender, gender identity and sexual orientation.

This information helps us improve health care and services. Your answers are confidential.

1. My gender is:

Transgender

Non-binary/third gender

Female

Male

These options don’t work for me. I describe myself as      \_\_\_\_\_\_\_\_\_\_\_\_

I don’t want to answer

1. My racial or ethnic identity is:

American Indian or Alaskan Native  Black or African American

Hispanic, Latino, Latina or Latinx  Middle Eastern/Northern African

Native Hawaiian or Pacific Islander  Asian

White

These options don’t work for me. I describe myself as      \_\_\_\_\_\_\_\_\_\_\_\_

I don’t want to answer

1. I am deaf or have difficulty hearing:

Yes

Don’t know

No

I don’t want to answer

1. I am blind or have difficulty seeing, even when I wear glasses:

Yes  I don’t know

No  I don’t want to answer

1. I have a physical, mental, or emotional condition that limits my activities:

Yes  I don’t know

No  I don’t want to answer

If Yes, please describe:

**HOW CAN WE HELP?**

We want to make it easier for you to be part of these meetings. What are some of the things that would help you participate?

1. This is what I need:

Language interpretation in this language      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Written material translation in this language      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone minutes  Internet access

Transportation  Child Care or Adult Dependent Care

**YOUR AGREEMENT**

* I promise that what I have written on this form is true and correct.
* I give permission for PacificSource to periodically check my enrollment in PacificSource Community Solutions (PSCS OHP).
* I agree to be part of the Community Advisory Council for two years.
* I will be part of at least four meetings a year.
* If I can’t come to a Community Advisory Council (CAC) meeting, I will let a Central Oregon Health Council staff person know ahead of time.

     

Your Signature Date

**Community Advisory Council**

**Dependent Information Form**

Please help your dependent(s) answer the questions below.

**Dependent #1:**

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_

Legal First Name Middle Initial Legal Last Name

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (dd/mm/yyyy)

1. How long have you (the dependent) been on PacificSource Community Solutions (PSCS OHP)?

Not at all

Less than 1 year

1-2 years

3-5 years

More than 5 years

More than 10 years

**RACE, ETHNICITY, LANGUAGE, AND DISABILITY**

1. My gender is:

Transgender

Non-binary/third gender

Female

Male

These options don’t work for me. I describe myself as      \_\_\_\_\_\_\_\_\_\_\_\_

I don’t want to answer

1. My racial or ethnic identity is:

American Indian or Alaskan Native  Black or African American

Hispanic, Latino, Latina or Latinx  Middle Eastern/Northern African

Native Hawaiian or Pacific Islander  Asian

White

These options don’t work for me. I describe myself as      \_\_\_\_\_\_\_\_\_\_\_\_

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Yes

Don’t know

No

I don’t want to answer

1. I am blind or have difficulty seeing, even when I wear glasses:

Yes  I don’t know

No  I don’t want to answer

1. I have a physical, mental, or emotional condition that limits my activities:

Yes  I don’t know

No  I don’t want to answer

If Yes, please describe:

**Dependent #2:**

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_

Legal First Name Middle Initial Legal Last Name

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (dd/mm/yyyy)

1. How long have you (the dependent) been on PacificSource Community Solutions (PSCS OHP)?

Not at all

Less than 1 year

1-2 years

3-5 years

More than 5 years

More than 10 years

**RACE, ETHNICITY, LANGUAGE, AND DISABILITY**

1. My gender is:

Transgender

Non-binary/third gender

Female

Male

These options don’t work for me. I describe myself as      \_\_\_\_\_\_\_\_\_\_\_\_

I don’t want to answer

1. My racial or ethnic identity is:

American Indian or Alaskan Native  Black or African American

Hispanic, Latino, Latina or Latinx  Middle Eastern/Northern African

Native Hawaiian or Pacific Islander  Asian

White

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Yes

Don’t know

No

I don’t want to answer

1. I am blind or have difficulty seeing, even when I wear glasses:

Yes  I don’t know

No  I don’t want to answer

1. I have a physical, mental, or emotional condition that limits my activities:

Yes  I don’t know

No  I don’t want to answer

If Yes, please describe:

**Dependent #3:**

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_

Legal First Name Middle Initial Legal Last Name

     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (dd/mm/yyyy)

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More than 10 years

**RACE, ETHNICITY, LANGUAGE, AND DISABILITY**

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Transgender

Non-binary/third gender

Female

Male

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1. I am blind or have difficulty seeing, even when I wear glasses:

Yes  I don’t know

No  I don’t want to answer

1. I have a physical, mental, or emotional condition that limits my activities:

Yes  I don’t know

No  I don’t want to answer

If Yes, please describe: