

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

PLEASE TYPE OR PRINT CLEARLY.

E-mail: macayla.claver@cohealthcouncil.org

FIRST NAME	МІ	LAST NAME			
			ICARIE)	 	
ORGANIZATIC	JIN/EIVIP	PLOYER (IF APPL	ICABLE)		
TELEPHONE	EM	AIL ADDRESS			
PHYSICAL AD	DRESS				
CITY 71	P (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):	Experience with being an Oregon Health Plan Member?			
American Indiana/Alaska Native	None			
Asian/Pacific Islander	Less than 1 year			
Black	1-2 years			
Hispanic	3-5 years			
White	More than 5 years			
Other	More than 10 years			
	aid (Oregon Health Plan) within the last two years. of a Medicaid member (OHP) within the last two			
3 0	or community organization)			
Can you attend daytime meetings?				
Yes – any time Yes – morning only				
Yes – afternoon only				
No				
·	ese meetings and other accommodations such as ed transportation, interpretation or any special			
my knowledge and belief. I agree to two years. I will attend and participation	y me on this form are true and correct to the best of serve on the COHC Community Advisory Council for ate in at least four meetings a year and any other If I am unable to attend, I will notify the COHC staff			
SIGNATURE OF APPLICANT	DATE			
•	ake someone a council member. COHC will choose sity and representation of other Medicaid members.			
If you are not selected for the CAC, activities in the future?Yes _	may we contact you to participate in other COHCNo			