Interest Form
Oregon Substance Use Disorder Treatment Accreditation Advisory Group

Purpose
The purpose of this form is to assist the Oregon Health Authority and its Director in evaluating the qualifications of an applicant for appointment to the Substance Use Disorder (SUD) Treatment Accreditation Advisory Group.

Applications must be submitted **no later than 5 p.m. Monday, December 23, 2019** to: SUD.AAG@dhsoha.state.or.us.

Application checklist
Before submitting your application, please use this checklist to make sure you didn't miss anything:
- ✓ Application form, including essay question (700 words maximum)
- ✓ Demographics form (optional)
- ✓ A resume, C.V. or narrative description of your professional or personal, clinical and/or administrative experience with SUD treatment delivery. *If you feel your essay question adequately describes your qualifications, please let us know in the body of your email.*

Personal data
Preferred title *(e.g., Mr., Mrs., Ms., Dr.):* _____

First name: _____ Last name: _____

Preferred pronouns: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Occupation: _____

Home phone: _____ Business phone: _____

Email: _____

Please indicate one category that you best represent:
- ☐ Community members
- ☐ Coordinated care organization clinicians
- ☐ Government agency
- ☐ Hospital
- ☐ Individuals/patients with lived experience
- ☐ Licensing board
- ☐ Medical association
- ☐ SUD treatment providers
- ☐ Tribal partner

Interest in appointment

To help us ensure the Advisory Group's representation spans diverse experiences and perspectives, please briefly describe:

- Your experience or expertise with SUD treatment, if any;
- Your lived experience with SUD treatment; and
- Any past experience on other SUD treatment advisory groups.

Provide your answers below or on a separate sheet of paper. Please limit answers to 700 words total.

Demographic information

To help us diverse representation on the Advisory Group, we would appreciate your demographic information. Please see attached form. This information is optional. Under state and federal law, this information may not be used to discriminate against you.

Signature

By submitting this form, I agree to accept appointment if selected by the Director:

Signature: _____ Date: _____

Race, Ethnicity, Language, and Disability (READLD)

Oregon Health Authority

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and disability background so that we can find and address health and service differences.

1. Do you need written materials in an alternate format (Braille, large print, audio recordings, etc.)?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

If yes, which format? _____

Race and Ethnicity

2. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

_____

3. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

American Indian and Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Asian

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Black and African American

- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

Hispanic and Latino/a/x

- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Middle Eastern/North African

- ☐ Middle Eastern
- ☐ North African

White

- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

Native Hawaiian and Pacific Islander

- ☐ Chamorro
- ☐ Guamanian
- ☐ Micronesian/Marshallese/ Palauan
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other Categories

- ☐ Other (*please list*)

  _____
- ☐ Don't know
- ☐ Don't want to answer

4. If you selected more than one racial or ethnic identity above, please **CIRCLE/SELECT the ONE that best represents your racial or ethnic identity**. If you have more than one primary racial or ethnic identity please check here: ☐

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Contact:

Program: Health Systems Division Phone: 800-527-5772 Email: SUD.AAG@dhsoha.state.or.us

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Language

5. In what **language** do you want us to:

Speak with you _____

Write to you _____

Please skip to question 8 if the person is under age 5

6. How well do you speak English?

- ☐ Very Well
- ☐ Well
- ☐ Not Well
- ☐ Not at all
- ☐ Don't know
- ☐ Don't want to answer

7a. Do you need an **interpreter** for us to communicate with you?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Don't want to answer

7b. If yes, what kind of interpreter do you need (***pick all that apply***):

- ☐ Spoken language interpreter (***please list***):

  _____
- ☐ American Sign Language
- ☐ Deaf Interpreter for DeafBlind and Deaf with additional barriers
- ☐ Contact sign language (PSE)
- ☐ Other (***please list***): _____

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential.

8. Are you **deaf** or do you have **serious difficulty hearing?**

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Don't want to answer

If yes, at what age did this condition begin? ____

9. Are you **blind** or do you have **serious difficulty seeing,** even when wearing glasses?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Don't want to answer

If yes, at what age did this condition begin? ____

10. Does a **physical, mental or emotional condition limit your activities** in any way?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Don't want to answer

11a. What is your age **today**? ____

11b. Please enter today's date: _____

Please stop now if the person is under age 5

12. Do you have serious difficulty **walking or climbing stairs?**

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Don't want to answer

If yes, at what age did this condition begin? ____

13. Do you have **difficulty dressing or bathing?**

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Don't want to answer

If yes, at what age did this condition begin? ____

14. Because of a **physical, mental or emotional condition,** do you have serious difficulty:

a. **Concentrating, remembering or making decisions?**

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Don't want to answer

If yes, at what age did this condition begin? ____

Please stop now if you/the person is under age 15

b. **Doing errands alone** such as visiting a doctor's office or shopping?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Don't want to answer

If yes, at what age did this condition begin? ____