Application for CareOregon's Member Advisory Council (MAC)

Name: _____

Address: _____ **Email:** _____

City: _____ **Zip code:** _____ **Phone:** _____

CareOregon Primary Care Provider or Clinic: _____

How long have you or your dependent been a Medicaid recipient? _____

How long have you or your dependent been a CareOregon member? _____

Have you ever served on a citizen advisory board or similar group? If so, which one and what was that experience like? (you can use back of form if you need more room) _____

_____

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_____

Please explain why you would like to serve on the Member Advisory Council: (you can use back of form if you need more room) _____

_____

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_____

Our goal is to have a Member Advisory Council that is as representative of the entire CareOregon membership as possible. The following information is helpful, but is optional -

Birthdate: Month_____ Day _____ Year _____ **Gender:** _____

Racial/Ethnic Background: _____

Thank you for your interest in the MAC and taking the time to fill out the application. If you have questions, please contact one of our MAC support staff: Melissa Sircy at 503-416-1479 or sircym@careoregon.org. After your application is received, we will call you to discuss the MAC.