MEMBER ADVISORY COMMITTEE
CalOptima Member Application

Fiscal Year 2018–2019

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-246-8635.

Name: _____ Phone: _____

Address: _____ Cell: _____

City, State, ZIP: _____ Fax: _____

Email: _____

This seat serves a two-year term ending June 30, 2020.

☐ **Consumer**

Current position (e.g., title, student, volunteer, retired, etc.):_____

_____

1a. What is your direct or indirect experience working with the CalOptima population you wish to represent on the Member Advisory Committee (MAC)?

_____

_____

_____

1b. Include any relevant community experience.

_____

_____

_____

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

_____

_____

_____

2b. Include relevant experience related to working with diverse populations.

_____

_____

_____

3. What is your current understanding of managed care systems and/or CalOptima?

4a. Please explain why you wish to serve on CalOptima's MAC.

4b. Please explain why you would be a qualified representative to serve on the MAC.

5. Do you speak any of CalOptima's threshold languages besides English (Spanish, Vietnamese, Farsi, Korean, Chinese or Arabic)? Please specify: _____

6. If selected, are you able to commit to a bimonthly MAC meeting as well as serve on at least one subcommittee? Yes ☐ No ☐

7. References (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website and, even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on the Member Advisory Committee requires that the person appointed must be a member or a family member or caregiver of a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

☐ **FAMILY MEMBER/CAREGIVER APPLICANT**

I understand that by my family member or caregiver applying to serve on the MAC, my status as a person eligible for Medi-Cal benefits is likely to become public. I authorize the incidental disclosing of my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

_____

Member (Printed Name)

_____ _____

Member (Signature) Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Federal HIPAA Privacy Regulations require that you complete this form to authorize CalOptima to use or disclose your protected health information (PHI) to another person or organization. Please complete, sign and return the form to CalOptima.

Date of Request: _____ Phone: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Medi-Cal beneficiary status and any information member chooses to disclose in connection with his or her application for appointment to the CalOptima Member Advisory Committee (MAC).**

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the CalOptima Member Advisory Committee (MAC).**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the applied for position.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

*** Revocation of this authorization will immediately terminate involvement in the MAC.*

RESTRICTIONS:

I understand that certain information (e.g. Medi-Cal beneficiary status and name) used or disclosed as a result of my signing this authorization may be further used or disclosed in accordance with the California Public Records Act. Information precluded from the Public Records Act maintained by CalOptima will not be used or disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf, must be attached to this form.)

Submit the completed application, your biography or résumé, and signed authorization forms to:

CalOptima
505 City Parkway West
Orange, CA 92868
Attn: Becki Melli

For questions, call **1-714-246-8635**.

Application must be received by May 25, 2018