



## Columbia Gorge Health Council Community Advisory Council Membership Application Form

This application is for community members who may be willing and interested in assisting one of the committees or project teams of the Columbia Gorge Health Council.

The Community Advisory Council (CAC) is chartered by the Columbia Gorge Health Council (CGHC) Governance Board to advise and make recommendations on the strategic direction of the organization. The CAC will guide the CGHC to remain responsive to consumer and community health needs.

All interested in applying for the CGHC Community Advisory Council should complete this form and return it to:

Columbia Gorge Health Council  
511 Washington Street, Suite 101  
The Dalles, OR 97058  
Email: [suzanne@gorgehealthcouncil.org](mailto:suzanne@gorgehealthcouncil.org)

PLEASE TYPE OR PRINT CLEARLY

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FIRST NAME	MI	LAST NAME
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ORGANIZATION/EMPLOYER (IF APPLICABLE)

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TELEPHONE	EMAIL ADDRESS
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PHYSICAL ADDRESS

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CITY	ZIP	COUNTY
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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.

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Please tell us why you want to be involved. What will your background or interests offer to the team? Limit to one to two paragraphs please. Attach more pages if needed.

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References: Please list two or three people below who can tell us about you

1)

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FIRST NAME	MI	LAST NAME
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ORGANIZATION/EMPLOYER (IF APPLICABLE)

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TELEPHONE	EMAIL ADDRESS
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2)

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FIRST NAME	MI	LAST NAME
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ORGANIZATION/EMPLOYER (IF APPLICABLE)

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TELEPHONE	EMAIL ADDRESS
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3)

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FIRST NAME	MI	LAST NAME
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ORGANIZATION/EMPLOYER (IF APPLICABLE)

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TELEPHONE	EMAIL ADDRESS
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Race/ethnicity (optional):

- American Indian/Alaska Native
- Asian/Pacific Islander
- Black
- Hispanic/Latino
- White
- Other

Experience with being an Oregon Health Plan Member?

- None
- Less than 1 year
- 1-2 years
- 3-5 years
- More than 5 years
- More than 10 years

What is your membership category? (check all that apply):

- Member – you are currently enrolled in Medicaid (Oregon Health Plan)
- Family member or legal guardian of a Medicaid member (OHP)
- Community Leader
- Community organization (name of community organization) \_\_\_\_\_

Are you a veteran or an active-duty member of the U.S. military?  Yes  No

Can you attend daytime meetings?

- Yes – any time
- Yes – morning only
- Yes – afternoon only
- No

We can provide transportation to these meetings and other accommodations such as language interpretation. Do you need transportation, interpretation or any special accommodations? If so, what?

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I certify that the statements made by me on this form are true and correct to the best of my knowledge and belief. I agree to serve on the CGHC Community Advisory Council for two years. I will attend and participate in at least four meetings a year and any other sub-committee meetings as needed. If I am unable to attend, I will notify the CGHC staff prior to the meeting.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

Completion of this form does not make someone a council member. CGHC will choose members based on geographic diversity and representation of other Medicaid members.

If you are not selected for the CAC, may we contact you to participate in other CGHC activities in the future?  Yes  No