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

PLEASE TYPE OR PRINT CLEARLY

FIRST NAME MI LAST NAME

ORGANIZATION/EMPLOYER (IF APPLICABLE) DATE OF BIRTH

TELEPHONE EMAIL ADDRESS

PHYSICAL ADDRESS

CITY ZIP COUNTY

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.

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.

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

1) _____

FIRST NAME MI LAST NAME

_____

ORGANIZATION/EMPLOYER (IF APPLICABLE)

_____

TELEPHONE EMAIL ADDRESS

2) _____

FIRST NAME MI LAST NAME

_____

ORGANIZATION/EMPLOYER (IF APPLICABLE)

_____

TELEPHONE EMAIL ADDRESS

3) _____

FIRST NAME MI LAST NAME

_____

ORGANIZATION/EMPLOYER (IF APPLICABLE)

_____

TELEPHONE EMAIL ADDRESS

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?

_____
_____
_____
_____

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