Dear Valued Member,

Thank you for your interest in the Molina Complete Care (MCC) Member Advisory Council (MAC)! We appreciate your enthusiasm for making MCC the best health plan.

The goal of MAC is to provide a space to share ideas to create a member-centered culture of providing care.

What is the Member Advisory Committee?
MAC is a group of members, family members, and community partners who represent the voice of our members. Committee members offer advice, information and recommendations to support member services, planning, policies and procedures.

What types of issues will the Committee address?
If selected as a MAC member, you will be the voice for member experience at MCC. The goals of the committee are:

- Attend monthly meetings.
- Open discussion of challenges faced by members, families, and the community to explore solutions MCC can implement.
- Represent MCC as leaders in the community for partnerships, advocacy, and governance.
- Members may be invited to join internal MCC committee meetings.
- Review and provide feedback on member communications to explore potential member impacts, barriers, and offer solutions. Projects may include:
    - Member Handbook
    - Member Orientation
    - Community Forums
    - Website
    - Marketing Materials
- Review member feedback through the use of surveys or calls conducted by MCC employees to discuss resolutions.
- Attend the Governance committee as an active member of MAC twice a year.

MAC meets virtually on the fourth Thursday of every month from 5:30-7 p.m. Our Member Experience Manager, Denise Jolley, is the MAC Facilitator.

We would like to get to know you! Please take a few minutes to complete the enclosed application and return it to: MCCAZ-OIFA@molinahealthcare.com.

Thank you for your time!

Sincerely,

MCC Member Advisory Council

Member Advisory Committee (MAC) Application

Thank you for your interest in joining the MAC. All personal information on this application will be kept confidential by Molina Complete Care. Please fill out and email this form to MCCAZ-OIFA@molinahealthcare.com.

Applicant name:			
Applicant address:			
City:		**State:**	**ZIP:**
Applicant email:	**Applicant phone number:**		
Best days and times for meetings (check all that apply): ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Morning ☐Afternoon ☐Evening		**Best time to contact applicant (check all that apply):** ☐Morning ☐Afternoon ☐Evening **Best way to contact:** ☐Email ☐Phone	
Are you, or is a member of your family, a Molina Complete Care member? (Membership must have been within the past year.)		☐Yes	☐No
Would you be receiving any payment for your participation in the MAC? (e.g., employer)		☐Yes	☐No
Please check the categories that best describe the experience you would bring to the MAC:			
☐Adult member receiving behavioral health services ☐Adult member receiving physical health services ☐Family of adult and/or child member ☐Family member of a child with special healthcare needs ☐Advocate ☐Provider ☐Community member and/or partner ☐Youth (age 18-25) ☐Other: _____			
Please explain why you would like to join the MAC:			

Please list three strengths and/or skills that would make you an effective MAC member:
1. 2. 3.
Please tell us what would help you have a positive MAC experience:
Please share any challenges or barriers that might get in the way of your participation:
Please tell us anything else you want us to know about your strengths, skills or experiences:
We want to make sure the MAC has a diverse group of people with different experiences and cultures. Please complete the following.

Age range:	**Race/Ethnicity:**	**Communities:**	**Languages:**	**Identified pronoun:**
☐18-25 years ☐26-35 years ☐36-55 years ☐55+ years	☐Caucasian ☐Hispanic, Latino/a ☐Black/African American ☐Asian ☐Native American Tribe: _____ ☐Other: _____	☐Veteran ☐LGBTQ+ ☐Peer ☐Family ☐Indigenous ☐Other	☐English ☐Spanish ☐Diné ☐Other: _____	☐She/Her ☐He/Him ☐They/Them ☐Other: _____