

**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](mailto:MCCAZ-OIFA@molinahealthcare.com).

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

**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**

**Age range:**

☐ 18-25 years

☐ 26-35 years

☐ 36-55 years

☐ 55+ years

**Race/Ethnicity:**

☐ Caucasian

☐ Hispanic/Latin

☐ Black/African American

☐ Asian

☐ Native American

☐ Other:  
\_\_\_\_\_

**Communities:**

☐ Veteran

☐ LGBTQ+

☐ Peer

☐ Family

**Languages:**

☐ English

☐ Spanish

☐ Dené

☐ Other:  
\_\_\_\_\_

**Preferred pronoun:**

☐ She/Her

☐ He/Him

☐ They/Them

☐ Other:  
\_\_\_\_\_