



COMMUNITY ADVISORY COUNCIL

APPLICATION

The goal of the Community Advisory Council (CAC) is to inform PrimaryHealth on how to best meet the needs of people enrolled in the Oregon Health Plan, as well as the whole community. Applicants selected to be a CAC member will reflect a diversity of people, skills and backgrounds to best serve the members and communities of the PrimaryHealth.

The Community Advisory Council will help the PrimaryHealth CCO:

- Meet the health care needs of OHP enrollees and the community
- Identify and advocate for preventive care services
- Oversee the Community Health Needs Assessment
- Recommend a Community Health Improvement Plan
- Evaluate CCO services
- Help the CCO clearly communicate with OHP enrollees and others
- And more!

NAME

PHONE

ADDRESS

CITY

ZIP CODE

EMAIL

Please check all that apply:

CURRENT PRIMARY HEALTH PLAN MEMBER

PARENT/GUARDIAN OF A PRIMARY HEALTH PLAN MEMBER

MEMBER NAME:

I WORK CLOSELY WITH PEOPLE ENROLLED IN THE OHP

I RESIDE IN JOSEPHINE COUNTY.

Please share why you would like to be a member of the Community Advisory Council of the PrimaryHealth:

What qualities or personal experiences do you have that could help the Community Advisory Council?

Please tell us how you have been active in your community. You may list community groups, committees, organizations or other service activities.

What do you think are some of the community's biggest health concerns?

Please give some examples of how you think PrimaryHealth could help improve some of the issues above.

How did you hear about the PrimaryHealth CAC?

I was referred by an existing member.

○ Name:

I was referred by my provider

○ Name:

I received a flyer in my new member handbook

I was at a community meeting hosted by the CAC.

○ Name of meeting:

Other:

If selected, I will serve on the Community Advisory Council (CAC) to the best of my ability. I will be an active Participant in the CAC meetings. If I am unable to attend the meetings, I will let the CAC co-chairs know before the meeting. Also, I understand that this completed application does not make me a member of the Community Advisory Council.

SIGNATURE: _____ DATE: _____

Please send your application to:

info@primaryhealthfamily.com

or

1867 Williams Hwy, Suite 108
Grants Pass, OR 97527
541-471-4208

PrimaryHealth thanks you for your application. You will be informed of our decision no more than 60 days after we receive your application.