Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

CALIFORNIA ADVANCING AND INNOVATION MEDI-CAL (CalAIM) ADVISORY COMMITTEE APPLICATION FORM

Name of Applicant: _____

E-mail Address: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Current Employer: _____

Work Address: _____ City: _____ Zip: _____

Work Phone: _____ Extension: _____

☐ Please check here to verify that you are not an Enhanced Care Management (ECM) / Community Supports (CS) provider and/or are not intending on becoming one (this includes those that work for an ECM/CS provider).

EXPERIENCE: What experience, training, education, or interests specifically qualify you as an appointee to the committee? (Please use an additional sheet of paper, if necessary, and attach it to this application.)

PUBLIC SERVICE: List past or present public service appointments or elected positions held (please list dates served):

PUBLIC SERVICE AGENCIES: List any affiliation you have with public service agencies in Ventura County:

AFFILIATIONS: List past or present affiliations with private and/or public health plans:

ORGANIZATIONS: List community organizations to which you currently belong:

COMMITTEES OR BOARDS: List any committees or boards on which you are currently serving:

CONVICTIONS AND PENALTIES: Have you ever been convicted of a felony? If yes, give date(s), location(s) and penalties. (Convictions are evaluated for each position and are not necessarily disqualifying.)

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QUESTIONS:

1. Why do you want to serve on the CalAIM Advisory Committee?

2. What strengths, skills, knowledge, and perspective would you bring to the CalAIM Advisory Committee?

3. Describe how you are currently working / engaged with our members?

REFERENCES: Provide a minimum of three references and their contact information:

1. Name: _____

   Affiliation: _____

   Contact Phone Number: _____

2. Name: _____

   Affiliation: _____

   Contact Phone Number: _____

3. Name: _____

Affiliation: _____

Contact Phone Number: _____

You are invited to include a copy of your resume or any supplemental information that you feel may assist in the evaluation of your application.

_____ _____

Signature (Must be signed in blue ink.) ***Date***

COMPLETE THE FORM AND RETURN IT TO:
Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
Attn: Maddie Gutierrez, Clerk of the Board
711 E. Daily Drive, Suite #106
Camarillo, CA 93010-6082

Or submit it by email to:
mgutierrez@goldchp.org

If you have any questions, call 1-805-437-5512.

Statement of Nondiscrimination and Language Assistance | Declaración de No Discriminación y Asistencia Lingüística

Gold Coast Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Gold Coast Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Gold Coast Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-301-1228 (TTY: 1-888-310-7347).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-301-1228 (TTY: 1-888-310-7347).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-301-1228 (TTY: 1-888-310-7347)。