

Community Advisory Committee (CAC) Member Application

Mail, fax, or email this completed form to Partnership

Partnership HealthPlan of California
ATTN: Member Services
4665 Business Center Drive, Fairfield, CA 94534
Email: cac@partnershiphp.org
Fax to: (707) 863-4415

Section 1: Member Information

Name:			
Mailing address:			
Mailing city:		Mailing zip code:	
Home address: <input type="checkbox"/> Same as mailing address			
Home city:		Home zip code:	
County in which member lives:			
Home phone:		Cell phone:	
Email address:			
How should we contact you:	<input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Other (<i>please state below</i>): _____		
Relationship to Partnership member:	<input type="checkbox"/> Member (Self) <input type="checkbox"/> Advocate / Parent / Guardian		

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Check which box you relate to:	<input type="checkbox"/> Female	<input type="checkbox"/> Other
	<input type="checkbox"/> Male	<input type="checkbox"/> Prefer not to answer
	<input type="checkbox"/> Trans woman	
	<input type="checkbox"/> Trans man	
Check which box you relate to:	<input type="checkbox"/> White	<input type="checkbox"/> Asian/ Pacific Islander
	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian Indian
	<input type="checkbox"/> Black	<input type="checkbox"/> Vietnamese
	<input type="checkbox"/> Native American	<input type="checkbox"/> Other (<i>please state below</i>):
	<input type="checkbox"/> Filipino	_____
We want CAC members to give input during meetings. Do you think you will be able to do this?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
CAC meets in-person 4 times a year. Will you be able to come to all of the meetings?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Section II: Member Experience		
Are you currently a member of any public service position, group, or committee? If yes, please list below: <i>*Note: This includes other Partnership committees.</i>		Dates served:
Why would you like to join Partnership's CAC? Please list any skills, abilities, or views that you could bring to CAC?		
Member Signature:		Date:

Note: Partnership HealthPlan of California is committed to equity, inclusion, and diversity. This form helps us move toward our goal of making sure that CAC reflects the members we serve.