MI Health Link Advisory Committee
APPLICATION/NOMINATION FORM

MDCH is forming an advisory committee for MI Health Link to provide a method for people to provide input on the demonstration.

For more information, see "MI Health Link Advisory Committee Frequently Asked Questions" at www.michigan.gov/mihealthlink.

Persons requesting assistance with the application process, contact 517 241-4293.

PERSONAL INFORMATION

Name		
Street Address		
City	State	Zip Code
Telephone		
E-Mail		
Preferred Method of Communication ☐ E-mail ☐ Mail ☐ Phone		

INTEREST IN PARTICIPATING

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

2. Do you have any interest in leading as Chair of the Advisory Committee?

   ☐ YES ☐ NO

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KNOWLEDGE/SKILLS/EXPERIENCE HIGHLIGHTS

1. List the qualities you have that will help the Advisory Committee achieve its goals. This can include knowledge, skills, work, education, or other life experiences.

2. Describe any experience being on councils, committees or advisory groups.

DIVERSITY EXPERIENCE

1. Describe your experience interacting with older adults, people with disabilities, people receiving behavioral health services, and/or people with complex medical conditions.

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2. Describe your experience interacting with people of different backgrounds.

COMPOSITION OF THE ADVISORY COMMITTEE

Complete all sections below that apply.

Section I.

☐ I am an (check all that apply):

- ☐ older adult
- ☐ adult with multiple chronic illnesses or functional or cognitive limitations
- ☐ adult with intellectual/developmental disabilities
- ☐ adult with physical disabilities
- ☐ adult receiving community based supports and services or nursing home services
- ☐ adult with serious mental illness
- ☐ adult with substance use disorders

☐ I am a family member, ally, or advocate of a person who is an (check all that apply):

- ☐ older adult
- ☐ adult with multiple chronic illnesses or functional or cognitive limitation
- ☐ adult with intellectual/developmental disabilities
- ☐ adult with physical disabilities
- ☐ adult receiving community based supports and services or nursing home services
- ☐ adult with serious mental illness
- ☐ adult with substance use disorders

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Section II.

☐ I represent a community-based or consumer advocacy organization.

Specify organization: _____

Population represented: _____

☐ I represent a provider/trade association (check service type(s) below):

- ☐ Primary/Acute Health Care
- ☐ Behavioral Health, Intellectual/Developmental Disability, Substance Use Disorder
- ☐ Long Term Services and Supports

Specify association: _____

☐ I represent another type of organization/affiliation.

Specify association: _____

Section III.

☐ I live, work in, and/or am familiar with communities in the following counties or regions (Check all that apply):

☐ Upper Peninsula	☐ Calhoun	☐ Van Buren	☐ Statewide
☐ Barry	☐ Cass	☐ Macomb	
☐ Berrien	☐ Kalamazoo	☐ Wayne	
☐ Branch	☐ St. Joseph	☐ Other counties	

REFERENCES

Please provide one personal or professional reference.

Name of Reference	
Telephone of Reference	E-Mail of Reference
Type of Reference ☐ Personal ☐ Professional (specify business/organization below)	

*You may attach one letter of reference. This is **OPTIONAL** and not required for the completion or consideration of the application.*

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SUBMISSION INSTRUCTIONS

Return a complete copy of this application form by e-mail, mail, or fax to:

E-mail: INTEGRATEDCARE@michigan.gov

Mail: Attn: Integrated Care Division
Michigan Department of Community Health
PO Box 30479
Lansing, Michigan 48909-7979

Fax: (517) 241-8995

If e-mailing for faxing this form, please put “Advisory Committee Application Form” in the subject line of your e-mail or fax.

Release of Information

All responses and information submitted in this application form may be subject to release under the Freedom of Information Act. As a member of this committee, your name may be made public on a roster or meeting minutes.