**CONSUMER READER APPLICATION FORM**

(Consumer Readers for One Care and Senior Care Options 2026 Procurement)

For more information, see “NOTICE OF OPPORTUNITY\_CONSUMER READER,” at:

EOHHS’ [procurement website](https://www.mass.gov/info-details/procurement-for-one-care-plans-and-senior-care-options-sco-plans-for-2026) or; [COMMBUYS](https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-23-1039-EHS01-ASHWA-84773&external=true&parentUrl=close)

|  |  |
| --- | --- |
| **NAME**       | **DATE**       |
| **JOB TITLE** (IF APPLICABLE)      | **ORGANIZATION** (IF APPLICABLE)      |
| **ADDRESS**      **CITY, STATE, ZIP CODE**       |
| **TELEPHONE**       | **EMAIL**       |

**[ ]  VOICE** **[ ]  VIDEOPHONE** **[ ]  TTY**

**PREFERRED METHODS OF COMMUNICATION:** **[ ]  EMAIL** **[ ]  MAIL** **[ ]  PHONE**

1. **QUALIFICATIONS**
2. INTEREST IN PARTICIPATING: Why do you want to be a Consumer Reader?

1. Consumer Reviewers will review **either** One Care or Senior Care Options (SCO) procurement materials. Do you prefer reviewing One Care or SCO procurement materials? Please explain why.

1. KNOWLEDGE/ SKILLS/ EXPERIENCE: List three qualities that you have that will help EOHHS achieve its goals and complete its work. This can include knowledge, work, education, or other lived experience. If applicable, include any relevant experience with or knowledge of One Care and/or Senior Care Options (SCO).

1. DIVERSITY EXPERIENCE: Describe your experience with people with disabilities or with people of different social, racial and cultural backgrounds, including deaf and LGBTQ communities, or any experience that shows a commitment to diversity.

1. AFFILIATIONS: Please check all that apply to you:

**SECTION 1**

**[ ]** I am a MassHealth member with a disability (Check applicable population(s) below that apply to you).

[ ]  I am a family member or guardian of a MassHealth member with a disability (Check applicable population(s) below).

POPULATIONS (check all areas that apply)

[ ]  adults with physical disabilities [ ]  adults with intellectual/developmental disabilities

[ ]  adults with serious mental illness [ ]  adults with substance use disorders

[ ]  adults with disabilities with multiples chronic illnesses or functional and cognitive limitations

[ ]  adults with disabilities who are unhoused or houseless

[ ]  I am a MassHealth member aged 65 or older.

[ ]  I am a family member or guardian of a MassHealth member aged 65 or older.

**SECTION 2**

**[ ]** I represent a community-based or consumer advocacy organization

* Specify organization and populations representing or serving

[ ]  I represent a provider/trade association (check service type below)

[ ]  Medical [ ]  Behavioral Health [ ]  Long-Term Services and Supports

[ ]  I represent a union. Union name:

POPULATIONS SERVED BY ORGANIZATION, ASSOCIATION, OR UNION (check all areas that apply):

[ ]  adults with physical disabilities [ ]  adults with intellectual/developmental disabilities

[ ]  adults with serious mental illness [ ]  adults with substance use disorders

[ ]  adults with disabilities with multiple chronic illnesses or functional and cognitive limitations

[ ]  adults with disabilities who are unhoused or houseless [ ]  older adults (aged 65 and older)

Do you receive pay or a salary from the organization, association, or union that you will be representing? [ ]  Yes [ ]  No

**SECTION 3**

**[ ]** I live/work in and/or have a strong connection with communities in the following county(s)

(Check all that apply):

[ ]  Barnstable [ ]  Berkshire [ ]  Bristol [ ]  Dukes [ ]  Essex

[ ]  Franklin [ ]  Hampden [ ]  Hampshire [ ]  Middlesex [ ]  Nantucket

[ ]  Norfolk [ ]  Plymouth [ ]  Suffolk [ ]  Worcester

1. LETTER OF REFERENCE (No more than 2 pages)

Attach one letter of reference from an individual, business or organization that can support your candidacy for this position.

1. **SUBMISSION INSTRUCTIONS**

Return a complete copy of this nomination form (with requested accommodations, as needed) with one letter of reference by e-mail to:

E-mail: Amy.Butcher@mass.gov

Please put “Consumer Reader Application Form” in the subject line of your e-mail.

**Applications must be received by EOHHS no later than September 15th, 2023, at 4:00 PM.**

**Public Records Notice:** In submitting this application form, you understand that any information contained within it, including voluntary self-identification as a recipient of MassHealth or Medicare coverage, may be made public. All responses and information submitted in response to this application form are subject to the Massachusetts Public Record Law, M.G.L. c. 66, § 10, and M.G.L. c. 4, § 7, subsection 26.