NOMINATION FORM

Implementation Council for One Care

The Implementation Council is a committee convened by the Massachusetts Executive Office of Health and Human Services (EOHHS) to provide input to and monitoring of the *Massachusetts State Demonstration to Integrate Care for Dual Eligible Individuals*, also known as One Care. The purpose of One Care is to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain health care costs for Dual Eligibles. The Council will meet through December 31, 2019; however, EOHHS in its sole discretion may terminate the terms of Implementation Council members sooner if the Demonstration ends. EOHHS has sole discretion to extend the contracts for Implementation Council members for up to an additional 2 years for any increment of time.

For more information, see "Frequently Asked Questions about the Implementation Council," at www.mass.gov/masshealth/duals under Related Information or on COMMBUYS (www.commbuys.com). [Directions for accessing the documents through COMMBUYS: (1) Scroll down to the bottom of the COMMBUYS home page and click on "Contract and Bid search." (2) On the next page click on Bids. (3) On the Advanced Search page enter the keyword "Implementation" in the Bid Description field; from the dropdown menu in the Organization field select 1039-Executive Office of Health and Human Services; click on "find it." (4) The link for the relevant documents should be at or very near the top of the list. Click on that link.]

ABOUT YOURSELF/THE NOMINEE

Name: _____ **Job Title (if applicable):** _____

Organization (if applicable): _____

Address: _____ **City, State, ZIP code:** _____

Telephone: _____ **E-mail:** _____

☐ **Voice** ☐ **Videophone** ☐ **TTY**

Preferred method of communication: ☐ **E-mail** ☐ **Mail** ☐ **Phone**

QUALIFICATIONS

INTEREST IN PARTICIPATING: Why do you want to serve on the Implementation Council?

_____

_____

_____

_____

_____

KNOWLEDGE/SKILLS/EXPERIENCE HIGHLIGHTS: List three qualities that you have that will help the Implementation Council achieve its goals and complete its work. This can include knowledge, skills, work, education, or other lived experience. If applicable, include any relevant experience with or knowledge of One Care.

_____

_____

_____

_____

_____

PLEASE turn to next page and complete required information

OUTREACH EXPERIENCE: Describe your experience/skills in this area.

_____
_____
_____
_____
_____

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.

_____
_____
_____
_____
_____

COMPOSITION OF THE IMPLEMENTATION COUNCIL

INDICATE YOUR AFFILIATION(S)
Complete all applicable sections.

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 multiple chronic illnesses or functional and cognitive limitations
☐ adults with disabilities who are homeless

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 illness or functional and cognitive limitations
☐ adults with disabilities who are homeless or have been homeless

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 am familiar with communities in the following county/ies (Check all that apply):

☐ Barnstable	☐ Berkshire	☐ Bristol	☐ Dukes	☐ Essex
☐ Franklin	☐ Hampden	☐ Hampshire	☐ Middlesex	☐ Nantucket
☐ Norfolk	☐ Plymouth	☐ Suffolk	☐ Worcester	

LETTER OF REFERENCE (1-2 pages total)

Attach one letter of reference from an individual, business or organization that can support your candidacy for this position. If you completed section 2 above and are applying to serve as an individual that represents an organization, association, or union, include a letter of reference from that entity.

SUBMISSION INSTRUCTIONS

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

E-mail: Gerry.sobkowicz@state.ma.us

Mail: Executive Office of Health and Human Services
Attn: Geraldine Sobkowicz, Procurement Coordinator
One Ashburton Place, 11th Floor
Boston, MA 02108
Office Phone: (617) 573-1714 Fax: (617) 573-1893

Please put "Implementation Council Nomination Form" in the subject line of your e-mail or fax or on the envelope if submitting by mail.

Nominations are due no later than Tuesday, January 10, 2017, at 5:00 PM.

Public Records Notice: In submitting this nomination form, you understand that any information contained within in 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 nomination form are subject to the Massachusetts Public Records Law, M.G.L. c. 66, § 10, and M.G.L. c. 4, § 7, subsection 26.

_____ _____

Applicant's Signature Date