

## Implementation Council for One Care Form

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 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 for an initial term of two years. 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/one-care](http://www.mass.gov/one-care) under "One Care Implementation Council," in "Notice of Opportunity to Join the One Care Implementation Council" or on COMMBUYS ([www.commbuys.com](http://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

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?

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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.

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

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DIVERSITY EXPERIENCE: Describe your experience with people with disabilities or with people of different social, racial and cultural backgrounds, including deaf/Hard of Hearing, blind/visually impaired, LGBTQ+ communities, homelessness/unstably housed, or any experience that shows a commitment to diversity.

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**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: \_\_\_\_\_

- 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):
- |                                     |                                    |                                    |                                    |                                    |
|-------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Barnstable | <input type="checkbox"/> Berkshire | <input type="checkbox"/> Bristol   | <input type="checkbox"/> Dukes     | <input type="checkbox"/> Essex     |
| <input type="checkbox"/> Franklin   | <input type="checkbox"/> Hampden   | <input type="checkbox"/> Hampshire | <input type="checkbox"/> Middlesex | <input type="checkbox"/> Nantucket |
| <input type="checkbox"/> Norfolk    | <input type="checkbox"/> Plymouth  | <input type="checkbox"/> Suffolk   | <input type="checkbox"/> 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 or mail to:

- E-mail:            EOHHS-Procurement@mass.gov
- Mail:             Executive Office of Health and Human Services  
                       Attn: Amy Butcher, Procurement Coordinator  
                       One Ashburton Place, 11<sup>th</sup> Floor  
                       Boston, MA 02108  
                       Office Phone: (617) 573-1709

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

**Nominations are due no later than May 15, 2024, 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.

\_\_\_\_\_  
 Nominee's Signature (electronic signature accepted)

\_\_\_\_\_  
 Date