NOMINATION FORM

Implementation Council for the Duals Demonstration

The Implementation Council is a new committee convened by the Massachusetts Executive Office of Health and Human Services (EOHHS) to provide input to and monitoring of a new program called the *Massachusetts State Demonstration to Integrate Care for Dual Eligible Individuals* (Duals Demonstration). The Council will meet through December 2016.

For more information, see "Frequently Asked Questions about the Implementation Council," at www.mass.gov/masshealth/duals.

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.

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

PLEASE turn to next page and complete required information

COMPOSITION OF THE IMPLEMENTATION COUNCIL

INDICATE YOUR AFFILIATION(S) (Complete all applicable sections.):

☐ 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

☐ 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: _____

☐ I represent another type of organization/affiliation. Specify: _____

☐ 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.

SUBMISSION INSTRUCTIONS

Return a complete copy of this nomination form with one letter of reference by e-mail, mail, or fax to:
E-mail: Geraldine.Sobkowicz@state.ma.us
Mail: Executive Office of Health and Human Services
Attn: Geraldine Sobkowicz
One Ashburton Place, 11th Floor
Boston, MA 02108
Office Phone: (617) 573-1678 Fax: (617) 573-1893
Please put "Implementation Council Nomination Form" in the subject line of your e-mail or fax.
Nominations are due no later than Monday, December 17, at 5 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.