NOMINATION FORM
Delivery System Reform Implementation Advisory Council ("Council")

The Delivery System Reform Implementation Advisory Council ("Council") is a committee convened by the Massachusetts Executive Office of Health and Human Services (EOHHS) to provide input and advice to and monitoring of MassHealth's delivery system reform efforts. The Council will meet through the upcoming 5-year 1115 Waiver extension period ending June 30, 2022. In its sole discretion, EOHHS may extend the term of the Council members by two years in any increment of time.

For more information, see "Frequently Asked Questions about the Delivery System Reform Implementation Advisory Council," at www.mass.gov/hhs/masshealth-innovations or on COMMBUYS (www.commbuys.com) by searching the Bid Description field for keyword Delivery System Reform.

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**
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QUALIFICATIONS

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

_____
_____
_____
_____
_____

KNOWLEDGE/SKILLS/EXPERIENCE HIGHLIGHTS: List three qualities that you have that will help the Council achieve its goals and complete its work. This can include knowledge, skills, work, education, or other personal experience. If applicable, include any relevant experience with or knowledge of MassHealth's payment reform efforts.

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

COMPOSITION OF THE COUNCIL:

Indicate your affiliations in Section 1 and/or Section 2 below:

Section 1: Members/Family Members
As noted below, a resume is optional for all individuals filling out section 1.

☐ I am a MassHealth member. (Check applicable population(s) below that apply to you)
☐ I am a family member or guardian of a MassHealth member. (Check applicable population(s) below.)

POPULATIONS (check all areas that apply):

☐ adults/children with physical disabilities ☐ adults/children with intellectual/developmental disabilities
☐ adults/children with serious mental illness ☐ adults/children with substance use disorders
☐ adults/children with disabilities with multiple chronic illnesses or functional and cognitive limitations
☐ adults/children with disabilities who are homeless
☐ adults/children who are homeless or have been homeless

Section 2: Advocates/Organization Representatives
As noted below, a resume is required for all individuals filling out section 2.

☐ I represent a Massachusetts hospital, ACO, Community Partner, or community health center serving the Medicaid population.
Specify organization and populations representing or serving: _____

☐ I represent a member or community organization that serves or represents people with disabilities and/or complex, medical conditions.
Specify organization and populations representing or serving: _____

☐ I am a clinical expert[1] in behavioral health, substance use disorders, and/or long-term care supports and services. I have significant expertise in clinical quality measurement of hospitals, primary care providers, community health centers, clinics and managed care plans. Significant expertise is defined as not less than five years of recent full-time employment in quality measurement in government service or from companies providing quality measurement services to above-listed provider types and managed care plans.
(check applicable service type(s) below)

☐ Medical ☐ Behavioral Health ☐ Long-Term Services and Supports

[1] Clinical experts are physicians, physician assistants, nurse practitioners, LCSWs, LMHCs, psychologists, and registered nurses.

GEOGRAPHIC COMPOSITION OF THE COUNCIL:

Indicate your geographic affiliations below:

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	

RESUME:

Attach a one page resume that highlights your qualifications to serve on the Council. **Please note that a resume is required for those applicants who have completed Section 2 and optional for those who have completed Section 1.**

SUBMISSION INSTRUCTIONS:

To be considered, interested individuals **MUST submit a nomination form and resume, if applicable, through COMMBUYS** by **December 12, 2016, at 12:00 PM.** Email and hard copy submissions will not be accepted. The nomination form and a frequently asked questions (FAQ) document are available online at http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/advisory-council.html, http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/advisory-council.html or on COMMBUYS (www.commbuys.com) by searching the Bid Description field for keyword Delivery System Reform. Contact Lisa Wong at Lisa.D.Wong@MassMail.State.MA.US or 617-573-1683 if you need the form and FAQ sent to you or would like to request a reasonable accommodation, which may include obtaining the information in an alternative format**.**

Nominations are due no later than December 12, 2016, at 12:00 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