

**District of Columbia Medical Care Advisory Committee (MCAC)**

**Member Application Form**

**Winter 2017**

**DHCF is accepting applications to fill one (1) spot on its MCAC.**  All applications must be submitted to Ms. Trina Dutta, Special Projects Officer, at D.C. Department of Health Care Finance, 441 Fourth Street NW, 900 South, Washington, DC 20001, or via e-mail at [trina.dutta@dc.gov](mailto:trina.dutta@dc.gov), by Monday, January 23, close of business.

Name: Click here to enter name.

Organization (if applicable): Click here to organization.

Role (if applicable): Click here to enter title.

Phone Number: Click here to enter phone number.

Email address: Click here to enter email address.

1. **Choose one of the following to best identify yourself:**

I am a health care provider (or representative of providers).

I am a board-certified physician.  Yes  No

I am a beneficiary/beneficiary advocate and may represent the following interests:

* Medicaid beneficiary;
* Individual legally responsible for a Medicaid beneficiary;
* Family member of Medicaid beneficiaries;
* Non-governmental social service agency; and/or
* Beneficiary advocate group.

1. **In less than 1000 words, explain why you should be considered for appointment to the MCAC.**  DHCF will consider the following in your response, at minimum:

* Demonstrated interest in the health care of District residents;
* Interest, willingness, and time to work in the program area of concern to the MCAC;
* Current or recent experience in the profession or group to be represented;
* Ability to explore and incorporate new and varied points of view;
* Awareness of special problems confronting those seeking help;
* Awareness of community needs for which programs can be developed and improved;
* Knowledge of how to make programs widely known in the community;
* Knowledge of how to design outreach programs for potential beneficiaries who are unaware that they are eligible for services;
* Knowledge of gaps in services;
* Knowledge of barriers to the use of services; and
* Knowledge of how to help beneficiaries become informed, knowledgeable users of services.

Click here to enter text. Your response must be no more than 1000 words.

1. **By signing here, you attest to the truth of statements provided in this application**. If chosen as an MCAC member, you agree to sign a conflict of interest form that discloses all material facts relating to any actual or potential conflicts of interest on occasions during your term.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Click here to enter a date.