



**TEXAS HEALTH AND HUMAN SERVICES COMMISSION
 MEDICAID/CHIP REGIONAL ADVISORY COMMITTEE
 PRINTABLE MEMBERSHIP APPLICATION FORM**

The completion of this application does not guarantee membership acceptance. Each application shall be weighed on the candidates' merits, the availability of a position in the candidate's specialty area, and the review process. **You may be appointed to a 2 or 3-year term.** Applications must be received by **February 26, 2010**

PLEASE PRINT CLEARLY.

First Name _____ MI _____ Last Name _____		
Organization/Employer _____		
Telephone: () _____ E-mail address: _____		
Physical Address: _____		
City: _____, Texas		Zip Code _____
Mailing Address: _____		
City: _____, Texas		Zip Code _____
Gender:	Female _____	Male _____

PLEASE SELECT THE REGION IN WHICH YOU WOULD LIKE TO SERVE. THIS LINK WILL DISPLAY THE REGIONAL MAP: http://www.hhs.state.tx.us/aboutHHS/HHS_Regions.shtml

- | | | |
|---------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> 1-Lubbock | <input type="checkbox"/> 4-Tyler | <input type="checkbox"/> 8-San Antonio |
| <input type="checkbox"/> 2-Abilene | <input type="checkbox"/> 5-Beaumont | <input type="checkbox"/> 9-San Angelo/Midland |
| <input type="checkbox"/> 3-Dallas | <input type="checkbox"/> 6-Houston | <input type="checkbox"/> 10-El Paso |
| <input type="checkbox"/> 3-Fort Worth | <input type="checkbox"/> 7-Austin | <input type="checkbox"/> 11-Rio Grande Valley |

RACE/ETHNICITY (OPTIONAL)

- American Indian/Alaskan Native
- Asian/Pacific Islander
- Black
- Hispanic
- White
- Other: _____

EDUCATIONAL BACKGROUND

- High School or GED
- Associate
- Bachelor
- Masters
- Doctorate
- Post-Doctorate

EXPERIENCE WITH MEDICAID/CHIP COMMUNITY

- None
- Less than 2 years
- 3-5 years
- More than 5 years
- More than 10 years

CHECK YOUR SPECIALTY AREA:

- | | |
|--|--|
| <input type="checkbox"/> Primary Care Provider (PCP) | <input type="checkbox"/> Managed Care Organization |
| <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Non-profit organization |
| <input type="checkbox"/> Behavioral Health Provider | <input type="checkbox"/> Local Health District |
| <input type="checkbox"/> Rural Provider | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Other Provider: _____ | <input type="checkbox"/> Rural Health Center |
| <input type="checkbox"/> Advocate | <input type="checkbox"/> Federally Qualified Health Center |
| <input type="checkbox"/> Consumer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Consumer Advocate | |

HAVE YOU EVER BEEN CONVICTED OF A FELONY? _____ IF YES, PLEASE EXPLAIN:

ARE YOU CURRENTLY A VOTING MEMBER IN ANY HHSC COMMITTEES OR COUNCILS?

No Yes. Please list them below; use additional page if necessary.

1- _____

2- _____

3- _____

4- _____

5- _____

