Member Advisory Committee (MAC) Application

Thank you for your interest in joining the MAC. All information on this application will be kept confidential by Molina Healthcare.

First and last name:

Street address:

Street address: | **State:** | **ZIP:**

Email: | **Phone number:**

Please select the days and times you are available to meet:

	Mon	Tues	Wed	Thurs	Fri
Morning					
Afternoon					
Evening					

Best time to contact (check all that apply):

☐ Morning ☐ Afternoon ☐ Evening

Best way to contact:

☐ Email ☐ Phone

Do you identify as a:

- ☐ Molina Healthcare Member
- ☐ Family/Caregiver of a Molina Healthcare Member
- ☐ Community Partner

If you are a member or family of a member, please choose the type of coverage:

- ☐ Medicaid only
- ☐ Dual enrollment, Medicaid and Medicare

We want to make sure the MAC has a diverse group of people with different experiences and cultures. Please complete the following.

Age range:
- ☐ 18-25 years
- ☐ 26-35 years
- ☐ 36-55 years
- ☐ 55+ years

Race/Ethnicity:
- ☐ White
- ☐ Hispanic/Latino/a
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian
  Tribe:
- ☐ Other:

Communities:
- ☐ Veteran
- ☐ LGBTQ+
- ☐ Peer
- ☐ Family
- ☐ Indigenous
- ☐ Other

Languages:
- ☐ English
- ☐ Spanish
- ☐ Diné
- ☐ Other:

Pronoun:
- ☐ She/Her
- ☐ He/Him
- ☐ They/Them
- ☐ Other:

Why would you like to join the MAC?

Is there anything we should know about you or your family? Is there anything that could impact your ability to participate in the MAC?

Please fill out and email this form to MCCAZ-OIFA@molinahealthcare.com.
For questions, please call Molina's OIFA Administrator at (602) 489-4165.