CalOptima Health Seeks Whole-Child Model Family Advisory Committee Candidates

The Whole-Child Model (WCM) was set up to bring services covered by California Children's Services (CCS) for Medi-Cal-eligible children and youth into a managed care plan benefit in 2018. A provision of the Whole-Child Model requires health plans to establish a family advisory committee.

The CalOptima Health Board of Directors welcomes input and recommendations from members and the community regarding CalOptima Health programs. As part of that, CalOptima Health encourages members and community advocates to become involved in the Whole-Child Model Family Advisory Committee (WCM FAC).

The WCM FAC is made up of members, family of members receiving CCS services and community advocates who serve them. The WCM FAC reports to the Board and is asked to:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Health's Whole-Child Model as directed by the Board and as permitted under applicable law
- Study, research and analyze issues assigned by the Board or generated by staff or the WCM FAC
- Help with communications between interested parties and the Board, and help the Board and staff receive public opinion on issues relating to CalOptima Health's Whole-Child Model
- Give recommendations on issues to the Board for its consideration and approval, as well as help with community outreach for CalOptima Health's Whole-Child Model and the Board.

CalOptima Health is currently seeking candidates to serve as authorized family members on WCM FAC. A $50 stipend will be paid for each meeting attended. The following seats are available:

- **Four (4) Authorized Family Member seats with terms beginning July 1, 2025 and running through June 30, 2027.**
- **One Authorized Family Member seat to fulfill an existing term through June 30, 2026.**

Applicants must be one of the following:

- An authorized representative – including parent, foster parent and caregiver – of a CalOptima Health member who is receiving CCS services
- A current CalOptima Health member 18–21 years old receiving CCS services
- A current CalOptima Health member over the age of 21 who was receiving CCS services until aging out

Interested individuals with knowledge of or experience with CCS should send a completed application, biography or resume, and the disclosure forms as soon as possible. Recruitment will remain open until seats are filled. Please send documents to:

CalOptima Health
505 City Parkway West,
Orange, CA 92868
Attn: Cheryl Simmons,
Office of the Clerk of the Board

or send via fax to **714-571-2479** or email csimmons@caloptima.org

For questions, please call **714-347-5785.**

Whole-Child Model Family Advisory Committee Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a resume or biography listing your qualifications and include signed authorization forms. For questions, please call 714-347-5785.

Name: _____ Primary Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

- ☐ Authorized representatives, which includes parents, foster parents and caregivers, of a CalOptima Health member who is currently receiving CCS services;
- ☐ CalOptima Health members ages 18–21 who are currently receiving of CCS services;
- ☐ Current CalOptima Health members over the age of 21 who had received CCS services before aging out

Five seats are available with a term beginning July 1, 2025, through June 30, 2027. One seat is available to fulfill an existing term through June 30, 2026.

* Interested candidates for the Whole-Child Model Family Advisory Committee (WCM FAC) member or family member seats must reside in Orange County and be enrolled in CalOptima Health Medi-Cal and/or CCS/WCM or must be a family member of an enrolled CalOptima Health Medi-Cal and CCS/WCM member. The member seat is eligible for a $50 per meeting stipend and round-trip mileage for in-person participation.

CalOptima Health Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima Health member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with CCS:_____

_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

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Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

If selected, are you able to commit to attending WCM FAC quarterly meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the WCM FAC? ☐ Yes ☐ No

If selected as a representative on WCM FAC, do you agree that you will complete the required compliance courses within the appointed time frame? ☐ Yes ☐ No

All advisory committee representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

Please supply two references (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima Health to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole-Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal Health Insurance Portability and Accountability Act (HIPAA), Privacy Regulations require that you complete this form to authorize CalOptima Health to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima Health.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.**
Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow CalOptima Health staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of the CalOptima Health Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima Health
Office of the Clerk of the Board
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima Health or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole-Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under HIPAA and will not be disclosed by CalOptima Health without separate authorization, unless disclosure is permitted by HIPAA without authorization or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of this authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Submit this application, along with a biography or resume to:

CalOptima Health
Attn: Cheryl Simmons
Office of the Clerk of the Board
505 City Parkway West
Orange, CA 92868

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org