CalOptima Health Seeks Candidates to Participate on its Member Advisory Committee

The CalOptima Health Board of Directors welcomes input and recommendations from the community on issues related to CalOptima Health programs. For this reason, the CalOptima Health Board encourages members and community advocates to become involved through an advisory group known as the **Member Advisory Committee (MAC)**.

The MAC advises the CalOptima Health Board of Directors and staff. The committee has 20 members representing the various constituencies that CalOptima Health serves. The committee's charge is to:

- Provide advice and recommendations to the CalOptima Health Board on issues concerning CalOptima Health programs, as directed by the CalOptima Health Board
- Engage in study, research and analysis of issues assigned by the Board or generated by the committee.
- Serve as a liaison between interested parties and the Board.
- Assist the Board in obtaining public opinion on issues relating to CalOptima Health programs.
- Initiate recommendations on issues for study to the CalOptima Health Board for their approval and consideration.
- Understand and have familiarity with the diverse cultural and/or social environments of Orange County, including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Facilitate community outreach for CalOptima Health and the Board

Currently, CalOptima Health is seeking candidates to participate on the MAC. The following seats are available for eligible members:

- **Medi-Cal Member or Authorized Family Member**
- **OneCare Member or Authorized Family Member**

Board-appointed Medi-Cal Members, OneCare Members, and Authorized Family Members are eligible to receive a $100 stipend and mileage reimbursement for each meeting attended.

The committee encourages interested individuals with knowledge and support of Medi-Cal and Medicare to apply. To apply or to nominate an individual for the Member Advisory Committee, please mail, fax or email the attached candidate application before April 15, 2026 to:

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

Fax: **714-571-2479** or email: csimmons@caloptima.org

If you have any questions, please call **714-347-5785**.

MEMBER ADVISORY COMMITTEE
MEMBER APPLICATION

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Phone: _____

Address: _____ Cell: _____

City, State, ZIP: _____ Fax: _____

Email: _____

I hereby submit my application for the following Member Advisory Committee (MAC) member representative seats through 2028 and understand that I will be paid a $100 stipend for each meeting I attend if I am chosen for one of the following seats:

☐ **Medi-Cal Member or Authorized Family Member Representative**

☐ **OneCare Member or Authorized Family Member Representative**

Current position (e.g., title, student, volunteer, retired, etc.):_____

_____

What is your direct or indirect experience working with the CalOptima Health population you wish to represent on the MAC?

_____

_____

_____

Include any relevant community experience.

_____

_____

_____

What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

Include relevant experience related to working with diverse populations.

What is your current understanding of managed care systems and/or CalOptima Health?

Please explain why you wish to serve on CalOptima Health's MAC.

Please explain why you would be a qualified representative to serve on the MAC.

For demographic purposes only, which group best describes your race? (One or more groups may be marked)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Prefer Not to Answer

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

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

References (professional, community or personal):

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

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

If selected as a representative on MAC, do you agree to complete the required annual compliance courses within the appointed timeframe? ☐ Yes ☐ No

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, as well as 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 Health's website and, even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal or OneCare is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal or OneCare programs, unless other disclosures are authorized by the eligible member. Because the position of Consumer Representative on the Member Advisory Committee requires that the person appointed must be a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the box below and sign this waiver to allow their name to be nominated for the advisory committee.

☐ **ONECARE MEMBER OR AUTHORIZED FAMILY MEMBER APPLICANT**

☐ **MEDI-CAL MEMBER OR AUTHORIZED FAMILY MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal and OneCare programs, a fact that is otherwise protected under state or federal law. I do not agree to disclose any other information protected by state or federal law.

_____

Member (Printed Name)

_____ _____

Member (Signature) Date

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

Federal 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: _____ Phone: _____

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):

Medi-Cal or OneCare beneficiary status and any information the member chooses to disclose in connection with his or her application for appointment to the CalOptima Health's Member Advisory Committee (MAC).

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 service as beneficiary representative on the CalOptima Health's Member Advisory Committee (MAC).**

EXPIRATION DATE:

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

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
Cheryl Simmons
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.

***Revocation of this authorization will immediately terminate your involvement in the MAC. ***

RESTRICTIONS:

I understand that certain information (e.g., Medi-Cal or OneCare beneficiary status and name) used or disclosed as a result of my signing this authorization may be further used or disclosed in accordance with the California Public Records Act. Information precluded from the Public Records Act maintained by CalOptima Health will not be used or disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or 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 the 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 receipt of this authorization.

Member Signature: _____ Date: _____

Submit the completed application, your biography or resume, and signed authorization forms to:

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

For questions, call **1-714-347-5785**