DHSS **Medicaid & Medical Assistance**

Español, 中文, Kreyòl ayisyen, العربية, or other languages: 1-866-843-7212.

Beneficiary Advisory Committee (BAC)
Membership Application

Scan here to fill out application electronically

Personal Information

Full Name: _____

Date of Birth: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Text ☐ Other

Email: _____

Phone Number: _____

County of Residence: ☐ New Castle ☐ Kent ☐ Sussex

Why are you interested in joining the BAC? (if more space is needed, please write on back of page)

If you could improve one thing about Delaware Medicaid, what would it be?

Can you travel to Smyrna for four (4) meetings per year?
(Not a requirement and reimbursement may be available)
☐ Yes ☐ No ☐ Maybe

Are you currently or previously enrolled in Medicaid?
☐ Yes ☐ No

Have you been a caretaker for someone enrolled in Medicaid?
☐ Yes ☐ No

Demographic Information

Age Group: ☐ 18-21 ☐ 22-30 ☐ 31-45 ☐ 46-65 ☐ 66+

Do you or someone in your household have a disability?
☐ Yes ☐ No ☐ Prefer not to share

Race/Ethnicity:
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino/a
☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Availability for Participation:
☐ Weekday Daytime ☐ Weekday Evenings ☐ Weekends ☐ Other: _____

How did you hear about us?

Agreement and Signature

I apply for membership in the Beneficiary Advisory Committee and agree to abide by its rules and regulations. I affirm that the information provided is true and accurate.

Signature: _____ Date: _____

For Office Use Only

Application Received By: _____ Date: _____
Membership Approved: ☐ Yes ☐ No
Remarks: _____