DHSS **Medicaid & Medical Assistance**

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

Medicaid Advisory Committee (MAC)

Membership Application

Scan here to fill out application electronically

Personal Information

Full Name: _____

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

Email: _____

Phone Number: _____

County of Residence: ☐ New Castle ☐ Kent ☐ Sussex

Race/Ethnicity (to accurately represent the diversity of the citizenship of Delawareans including those who support the Medicaid program):
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino/a
☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

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Experience

Which of the following best describes you? (select up to 3 responses)

☐ Current or past DMMA MCAC member

☐ Member of DMMA Beneficiary Advisory Council (BAC)

☐ Member/Employee/Board Member of State or local advocacy group

☐ Member/Board Member of a Community Based Organization experienced with supporting people who receive Medicaid

☐ Other public service agency experienced with support people with Medicaid (Foster care, mental health, social services or public health)

☐ Provider of Medicaid services (clinical services)

☐ Provider of Medicaid services (direct support professional)

☐ Other Provider of Medicaid services

☐ Employee/Board Member of Managed Care Organization (MCO)

☐ Other _____

How long have you had experience working with people who use the Medicaid program? (select one)

☐ up to 1 year of experience ☐ 2-4 years of experience ☐ 5+ years of experience

What types of Medicaid groups do you have experience working with? (select all that apply)

☐ Aged, blind, disabled adults

☐ Children

☐ Parents/caretaker relatives with dependent children

☐ Pregnant women

☐ Low-income singles/childless couples

☐ Foster care children

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

Availability

Can you travel to New Castle County for four (4) meetings per year?
(Not a requirement)

☐ Yes ☐ No ☐ Maybe

Availability for Participation:

☐ Weekday Daytime ☐ Weekday Evenings ☐ Weekends ☐ Other: _____

How did you hear about us?

Where to send completed application:

Email to: DMMA_MACBAC@Delaware.gov

OR

Mail to: Division of Medicaid and Medical Assistance
Health and Social Services Campus
Lewis Building
1901 N. DuPont Highway
New Castle, DE 19720

Agreement and Signature

I apply for membership in the Medicaid 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: _____