OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

CalOptima Seeks Candidates to Participate on its OneCare Connect Member Advisory Committee 2017–18

OneCare Connect is a new health plan offered by CalOptima that combines Medicare and Medi-Cal, including long-term services and supports, into a single health plan.

The CalOptima Board of Directors welcomes input and recommendations from its members and the community regarding CalOptima programs. For this reason, the CalOptima Board encourages members and community advocates to become involved through an advisory group known as the OneCare Connect Member Advisory Committee (OCC MAC).

The **OCC MAC** advises the CalOptima Board of Directors and staff. The OCC MAC is composed of 10 voting members representing the various constituencies that OneCare Connect serves. The charge of the committee is to:

- Provide advice and recommendations to the CalOptima Board on issues concerning OneCare Connect programs as directed by the CalOptima Board, and as permitted under the law.
- Engage in study, research and analysis of issues assigned by the Board or generated by the OCC MAC.
- Serve as liaison between interested parties and the Board.
- Assist the Board in obtaining public opinion on issues related to OneCare Connect programs.
- Initiate recommendations on issues for study to the CalOptima Board for their consideration and approval.
- Facilitate community outreach for OneCare Connect and the Board.

At this time, CalOptima is seeking candidates, including an OneCare Connect member and/or family member of a OneCare Connect member to participate on its OCC MAC. **Service on the OCC MAC is voluntary and with no salary.** The following seat is available:

- **OneCare Connect member or family member of a OneCare Connect member***

The committee encourages interested individuals with knowledge and support of OneCare Connect, Medicare, Medi-Cal and dual eligible populations to apply.

To apply or to nominate an individual for the OneCare Connect Member Advisory Committee, please mail, fax or email the attached candidate application by **July 28, 2017,** along with a **biography or résumé** and the **CalOptima Authorization Disclosure forms** to:

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

CalOptima
Attn: Becki Melli
505 City Parkway West
Orange, CA 92868
Fax: 714-481-6469

Email: bmelli@caloptima.org

If you have questions, please call **714-246-8635**.

* Applicants for the OneCare Connect member or family member seats must reside in Orange County and maintain enrollment as an OneCare Connect member or must be a family member of an enrolled OneCare Connect member.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OneCare Connect Member Advisory Committee (OCC MAC)
Member Application
Fiscal Year 2017–2018

Instructions: Please answer all questions and type or print clearly. This application is for current OneCare Connect members and/or family members. Please attach a résumé or biography outlining your qualifications, and signed CalOptima Authorization Form. For questions, please call **1-714-246-8635**.

Name: _____ Work Phone: _____

Address: _____ Mobile Phone: _____

City, State, ZIP: _____ Fax Number: _____

Date: _____ Email: _____

These seats serve a two-year term ending June 30, 2019:

☐ **OneCare Connect member or family member***

* Applicants for the OneCare Connect member or family member seats must reside in Orange County and maintain enrollment as an OneCare Connect member or must be a family member of an enrolled OneCare Connect member.

OneCare Connect status (i.e., member or family member): _____

If you are a family member, please provide the member's name, and what your relationship is to the member: _____

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

_____

_____

_____

2a. Please explain why you would be a good representative for diverse and/or special needs populations. _____

_____

_____

_____

2b. Include any relevant experience working with these populations: _____

_____

_____

_____

_____

3. Please provide a brief description of your knowledge or experience as a dual eligible member (i.e., Medi/Medi), a member with traditional Medicare or a member in a Medicare Advantage Plan:

_____

_____

_____

_____

4. Please explain why you wish to serve on the OCC MAC: _____

_____

_____

_____

5. Please describe why you would be a qualified representative for service on the OCC MAC:

_____

_____

_____

_____

6. Other than English, do you speak any of CalOptima's threshold languages for the OneCare Connect program (Spanish, Vietnamese, Korean and/or Farsi)? _____

7. If selected, are you able to commit to attending a monthly OCC MAC meeting as well as serve on at least one subcommittee? ☐ Yes ☐ No

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

Name: _____ Relationship: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Email: _____

Name: _____ Relationship: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Email: _____

Please sign the below *Public Records Act Notice* and *Limited Privacy Waiver*. You also need to sign the attached *Authorization for Use or Disclosure of Protected Health Information* form to enable CalOptima 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 résumés, 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**

Continued on next page…

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on the OneCare Connect Member Advisory Committee requires that the person appointed must be a member or a family member or caregiver of a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member 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 OCC MAC, I am disclosing my eligibility for the Medi-Cal 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/CAREGIVER APPLICANT**
I understand that by my family member or caregiver applying to serve on the OCC MAC, my status as a person eligible for Medi-Cal benefits is likely to become public. I authorize the incidental disclosing of my eligibility for the Medi-Cal 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.

_____
OneCare Connect Member (Printed Name)

_____ _____
OneCare Connect Member (Signature) **Date**

Submit the completed application and résumé or bio, signed *Public Records Act Notice* and ***Limited Privacy Waiver* form and also the *Use or Disclosure of Protected Health Information* form to the address below by July 28, 2017.**

CalOptima
505 City Parkway West
Orange, CA 92868
Attn: Becki Melli

Fax: **1-714-481-6469**
For questions, call **1-714-246-8635** or email bmelli@caloptima.org.

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-855-705-8823**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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

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

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, 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 beneficiary status and any information member chooses to disclose in connection with his or her application for or appointment to the CalOptima OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) advisory committee**

Person or organization authorized to received 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 OneCare Connect Plan (Medicare-Medicaid Plan) 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
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima 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 the health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient 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.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

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.)