The Department is seeking nominations for participants in the Community Options Advisory Council. This Council must include a majority of consumers (i.e., individuals with disabilities, older adults, and their representatives) according to Federal regulations and ongoing guidance. Additional members of the Council may include professional advocates for consumers; provider representatives such as labor unions or professional organizations; lawmakers; health policy professionals; direct service or health care providers; and other interested community members.

Nominations for participation will be reviewed by the Department to ensure balanced representation and the required majority of consumers. Nominees will be contacted directly by the Department regarding appointment. Meetings or workgroups of the Council are open to the public to allow for additional participation by interested parties.

Membership Requirements:

1. Council must maintain a consumer majority.
2. To maintain membership, members must attend at least 60% of the scheduled meetings each calendar year.
	1. Attendance will be taken at each meeting and the member must attend in person or via telephone.
	2. A council member may send a substitute on his or her behalf, but must notify the Department in advance. The substitute must represent the same organization, affiliation or membership category as the member. A provider or professional advocate may not represent a consumer. This substitute will not count towards attendance.
3. Additional solicitations for membership may be sent out if membership changes.

Please complete the information on the next page to nominate individuals or yourself for the Community Options Advisory Council.

Name: Click here to enter text.

Address: Click here to enter text.

Phone: Click here to enter text.

E-mail: Click here to enter text.

**Professional Nominees**

Organization/Group(s) Represented (if applicable): Click here to enter text.

Other Affiliations: Click here to enter text.

**Consumer Nominees**

|  |  |  |
| --- | --- | --- |
| Are you, or the nominee, an individual with a disability, older adult, or the personal representative of an individual with a disability or an older adult? | [ ]  YES | [ ]  NO |
| Are you, or the nominee, a current or former Medicaid recipient?   | [ ]  YES | [ ]  NO |
| Are you, or the nominee, currently a participant or supporter of a participant in one of the following Medicaid programs?  | [ ]  YES | [ ]  NO |

 If yes, please check next any program in which they participate:

|  |  |
| --- | --- |
|[ ]  Community Personal Assistance Services |[ ]  Community Pathways |
|[ ]  Increased Community Services |[ ]  Community Supports Waiver |
|[ ]  Home and Community Based Options Waiver  |[ ]  Family Supports Waiver |
|[ ]  Community First Choice |[ ]  Autism Waiver |
|[ ]  Brain Injury Waiver |[ ]  Model Waiver |
|[ ]  Medical Day Care Waiver |[ ]  REM |
|[ ]  PACE |

**To be completed by all nominees**

Statement of interest and qualifications: Click here to enter text.