Consumer and Family Advisory Committee (CFAC) Application

Alliance CFAC promotes a community-based support system that seeks to have each person reach his or her full potential. This committee of individuals and family members gives voice to the interests and opinions of persons with needs related to mental health, intellectual and developmental disabilities, traumatic brain injury, and substance use. It embraces the dignity of all residents in our communities so that each person may achieve his or her highest level of responsibility in the community. It promotes the empowerment of individuals and the active involvement of family members.

Adult individuals are qualified to be advisory members of the committee if they or a member of their family is a consumer of mental health, intellectual and developmental disabilities, substance use disorder, or traumatic brain injury services.

You can learn more about CFAC at AllianceHealthPlan.org/about/governance/consumer-and-family-advisory-committee-cfac/. Alternatively, you can complete and submit this paper form via email or snail mail.

General information

1

Full name* _____ Date (mm/dd/yyyy)* _____

Address line 1* _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City* _____ State* _____ Postal Code* _____

Current employer (if applicable): _____

Title:* _____

Email* _____ Phone* _____

Is this a cell phone?* ○ Yes ○ No

Demographic information (confidential)

2

How do you define your gender identity?*

○ Male ○ Female ○ Transgender female ○ Transgender male

○ Gender fluid/queer ○ Non-binary ○ Other: _____

○ Choose not to disclose

What pronouns do you want people to use to describe you?*

○ She/her/hers ○ He/him/his ○ They/them/theirs

○ Other: _____ ○ Decline to answer

Demographic information (confidential)

Continued

2

Ethnicity:* ○ Hispanic or Latino ○ Not Hispanic or Latino

Race (Choose all that apply):*

☐ African American or Black ☐ Asian

☐ American Indian or Alaska Native ☐ White/Caucasian

☐ Native Hawaiian or Other Pacific Islander ☐ Prefer not to answer

☐ Other: _____

Age:* Please Select One: Shirt Size:* Please Select One:

Connection to MH/DD/SUD community

3

I am:* ○ an Alliance Health consumer (currently or awaiting services)

○ a family member of an Alliance Health consumer (i.e. parent, spouse, etc)

Which disability category do you identify with for representation?* (Please check all that apply.)

☐ Mental health (MH) ☐ Developmental disabilities (DD)

☐ Substance use disorder (SUD) ☐ Traumatic brain injury (TBI)

Do you have transportation?* ○ Yes ○ No

Do you need any special accommodations to attend meetings virtually or in person?* ○ Yes ○ No

Do you have any dietary restrictions?* ○ Yes ○ No

If yes, please describe:

_____

How did you hear about CFAC?*

☐ Email listserv ☐ Social media ☐ Disability-related group

☐ Disability advocate ☐ Friend ☐ Family

☐ Event ☐ Other: _____

Connection to MH/DD/SUD community

Continued

3

Do you work directly for or contract with any of the following?

☐ Local LME/MCO ☐ Provider agency ☐ Advocacy group

If yes, please describe:

Please briefly explain why you would like to join Alliance CFAC:*

Please feel free to include a brief summary of your lived experience (optional).

☐* I attest that I shall not participate in clinical or administrative activities or decisions in which there is or may be perceived a conflict of interest. As a CFAC member I will make decisions in a manner that is fair, objective, consistent, and with the interest of Alliance Health's members and recipients in mind to ensure the integrity of Alliance Health's business practices.

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge.

Signature (name or typed)*	Date (mm/dd/yyyy)*
x	

Submission instructions

Email: If you completed the paper form, or the fillable PDF, please email your completed application via secure email to CHWBReferrals@AllianceHealthPlan.org.

Mail: You may also mail your application to Alliance Health, c/o CFAC, 5200 West Paramount Parkway, Suite 200, Morrisville, NC 27560.

Thank you for your interest!

After we receive your submission, someone from Alliance Health will contact you regarding next steps.