Application for Membership on the Indiana Medicaid Advisory Committee (MAC)

Do not leave any question blank

1. Full Name
2. Employer Name
3. Employment Title
4. Address
5. County of Residence
6. Phone Number
7. Email

8. Select the option that best describes your relation to IN Medicaid
    a. I am a current IN Medicaid member.
    b. I was an IN Medicaid member in the past, but am not now.
    c. I am the family member/caretaker of an IN Medicaid member.
    d. I am a member of the Indiana Senate or Indiana House of Representatives
    e. I work with Indiana Medicaid.
        i. Please explain.
    f. Other.
        i. Please explain.

9. Please select/explain all that apply:
    a. I represent a Medicaid Provider.
        i. List type of Provider:
    b. I represent an Indiana Medicaid Managed Care Entity.
        i. List MCE:
    c. I represent a state or local consumer advocacy group or another community-based organization that represents the interests of, or provides direct service to Medicaid beneficiaries.
        i. List the group or organization with which you are affiliated:
        ii. Explain how you are affiliated with the group:
        iii. Describe the group or organization's affiliation to Indiana Medicaid:
    d. I am a member of the Indiana Senate or Indiana House of Representatives.
    e. I am a member of the Indiana Medicaid Beneficiary Advisory Council (BAC).

10. Please tell us why you are interested in being appointed to serve on the Indiana Medicaid Advisory Committee.