INLAND EMPIRE HEALTH PLAN

Enrollee Advisory Committee

IEHP DUALCHOICE MEMBER APPLICATION

Thank you for your interest in serving on the Enrollee Advisory Committee (EAC) for IEHP DualChoice (HMO D-SNP). Please call us at IEHP DualChoice Member Services at 1-877-273-4347 (TTY 1-800-718-4347) if you have any questions.

Please PRINT or TYPE. Feel free to use extra sheets, if needed.

CONTACT DETAILS

Name:

Preferred Name:

IEHP DualChoice Member ID#:

Date of Birth:

Address:

Email:

Phone Number:

Have you been an IEHP DualChoice member for less than 12 months?

☐ Yes ☐ No ☐ I don't know

Briefly tell us why you want to serve as a member of the EAC:

Are you getting In-Home Supportive Services (IHSS)?

☐ Yes ☐ No ☐ I don't know

Are you a parent, guardian, or caregiver of a minor or dependent adult?

☐ Yes ☐ No ☐ I don't know

Are you taking part in Community-Based Adult Services (CBAS)?

☐ Yes ☐ No ☐ I don't know

Do you identify as a person with a disability? ☐ Yes ☐ No

If "Yes," please describe your disability (below):

Do you have a chronic condition(s)? ☐ Yes ☐ No

If "Yes," please list your condition(s) (below):

CENSUS: PEOPLE IN THE I.E.

Which group best describes your race? (One or more groups may be marked)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Some other race
- ☐ Declined

What is your background? (Please check one)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined
- ☐ Other, please name:

LANGUAGE

What is your main language?

How well do you speak English? (Please check one)

- ☐ Very Well
- ☐ Well
- ☐ Not Well
- ☐ Not at all
- ☐ Declined
- ☐ Not at hand

Would you like an interpreter? (Please check one)

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Declined
- ☐ Not at hand

What is your preferred language for your health care needs? (Please check one)

- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ Hebrew
- ☐ Hmong
- ☐ Ilocano
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Lao
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Samoan
- ☐ American Sign Language (ASL)
- ☐ Spanish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Vietnamese
- ☐ Do not know
- ☐ Not at hand
- ☐ Declined
- ☐ Other, please name:

LANGUAGE (continued)

In which language would it be best for you to get written medical or health care instructions? (Please check one)

- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ Hebrew
- ☐ Hmong
- ☐ Ilocano
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Lao
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Samoan
- ☐ Spanish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Vietnamese
- ☐ Do not know
- ☐ Not at hand
- ☐ Declined
- ☐ Other, please name:

If you did not select English, Spanish, Chinese, or Vietnamese, please note that you can call Member Services at 1-877-273-4347, 8am-8pm, 7 days a week, including holidays, for a live interpreter translation of your written materials.

For English, Spanish, Chinese, and Vietnamese readers: Do you require written material in an alternate format? (Please check one).

- ☐ Braille (English and Spanish only)
- ☐ Large Print
- ☐ Electronic
- ☐ Audio CD
- ☐ Text to American Sign Language (ASL)

SEXUAL ORIENTATION AND GENDER IDENTITY

Sex Assigned at Birth

- ☐ Female
- ☐ Male
- ☐ Unknown
- ☐ Choose not to tell
- ☐ X/some other sex
- ☐ Details are not at hand

Gender Identity

- ☐ Female
- ☐ Male
- ☐ Transgender male/trans man/female-to-male (FTM)
- ☐ Transgender female/trans woman/male-to-female (MTF)
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Added gender group or other, please name:
- ☐ Choose not to tell
- ☐ Details are not at hand

SEXUAL ORIENTATION AND GENDER IDENTITY (continued)

What are your pronouns?

- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Theirs
- ☐ Other, please specify:
- ☐ Choose not to tell
- ☐ Details are not at hand

Sexual Orientation

- ☐ Lesbian or gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Pansexual
- ☐ X/another sex
- ☐ Something else, please name:
- ☐ Choose not to tell
- ☐ Details are not at hand

Have you served on an EAC type of body before?

How long have you been a IEHP DualChoice member?

Would you be able to work closely with IEHP DualChoice to offer ideas on policies and programs?

Do you see any barriers to taking part in EAC meetings? (Your response will not affect your eligibility.)

Would you be able to serve a one-year or two-year term?

Which days/time of the week are you not able to serve in the EAC?

IEHP DualChoice (HMO D-SNP) is an HMO plan with a Medicare contract.
Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.

IEHP