



COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING APPLICATION For Stakeholder Groups

Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

FOR WHICH GROUP ARE YOU APPLYING?			
Name (Last, First, Middle)	Home Address		County
City, ST, Zip Code	Home Phone ()	Business Phone ()	E-mail Address

Please provide a brief overview of your qualifications and/or an explanation as to why you would like to serve on this group.

Area(s) of interest? (Please check all that apply.)	Children's Services <input type="checkbox"/>	Rural/Non Urban <input type="checkbox"/>
	Client <input type="checkbox"/>	Developmental Disability <input type="checkbox"/>
	Community Based Service Provider <input type="checkbox"/>	Advocate <input type="checkbox"/>
	Elderly <input type="checkbox"/>	Eligibility Determination <input type="checkbox"/>
	Disability Community <input type="checkbox"/>	Medical Services Provider <input type="checkbox"/>
	Mental Health <input type="checkbox"/>	Other (describe) <input type="checkbox"/>
	Policy/Delivery System <input type="checkbox"/>	

Demographic Information: A response to the following is optional, but is encouraged. The information will be used to ensure groups are staffed with equal representation from all demographic areas.

Present Employer/Occupation	Date of Birth	Level of Education Completed/	Gender M F
Registered Voter Y N	Party Affiliation Dem Rep In	Race: African Am Asian Hispanic Native Am Caucasian Other	

I certify that the facts contained in this application are true and correct to the best of my knowledge. I further understand that the Colorado Open Records Act may require that certain information contained in this application be available for inspection by the general public.

SIGNATURE _____ DATE _____

*Signature Required

RETURN COMPLETED FORM TO:

Colorado Department of Health Care Policy and Financing
 1570 Grant Street
 Denver, CO 80203
 Fax: (303) 866-4411

Reasonable accommodations will be provided upon request in order for persons with disabilities to participate as a group member. Please notify the Boards & Committees Coordinator if you require assistance in completing the application or in serving on an HCPF stakeholder group.