MyCare
HEALTH CENTER

BOARD MEMBER APPLICATION

All questions contained in this questionnaire are strictly confidential.

Name:
(Last, First, M.I.) _____

Address: _____
(Street, City, ST, Zip) _____

Employer : _____
(If applicable)

Resume: attach if available

Preferred Method of Contact:

☐ Cell Phone: _____
☐ Home Phone: _____
☐ Email: _____

Are you a consumer of the Health Center?

☐ Yes ☐ No

If you are not a consumer of the Health Center, would you become one?

☐ Yes ☐ No

How did you hear about MyCare? _____

Why would you like to be a MyCare Board of Director? _____

_____

REQUIRED INFORMATION

Training and/or Experience: (Please Check all that apply)

☐ Management
☐ Banking
☐ Law
☐ Social Services
☐ Health Care Delivery
☐ Marketing/Public Relations
☐ Human Resources/Management
☐ Community Affairs
☐ Accounting
☐ Administration
☐ Government
☐ Local Business Owner

Type: _____

Do you have any relatives employed at MyCare Health Center? ☐ Yes ☐ No

Comments:

Other Life Skills:

Special Skills, Training, or Experience:

Community Activities or Special Contributions:

OPTIONAL INFORMATION

We collect statistics on all Board members and patients we serve because we receive federal grant funds. You have the right to refuse to give this information, however, it may limit the services or programs we are able to deliver to our consumers. (Declining to respond to these questions will not be held against you.)

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

Race:

- ☐ Caucasian
- ☐ African American
- ☐ Asian
- ☐ Native American
- ☐ Arabic/Chaldean
- ☐ Other: _____

Do you consider yourself low income? ☐ Yes ☐ No

Sexual Orientation / Gender Identity: (Please check all that apply)

- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Something Else
- ☐ Choose not to disclose
- ☐ Straight
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Other _____
- ☐ Choose not to disclose

Age:

- ☐ 18-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-64
- ☐ 65+

Insurance Type:

- ☐ Medicaid
- ☐ Medicare
- ☐ Marketplace
- ☐ Private
- ☐ Uninsured

Other information:

Have you served in the Armed Forces? ☐ Yes ☐ No

Type of Discharge: _____

Do you have a history of behavioral health issues? ☐ Yes ☐ No

Do you have a substance use disorder? ☐ Yes ☐ No

Are you or a family member homeless? ☐ Yes ☐ No

Are you or a family member a migrant farm worker? ☐ Yes ☐ No

Do you have any special needs that you would like the Board to be made aware of? ☐ Yes ☐ No Please specify: _____

NOTICE: Read Carefully and Sign

I understand that my Board membership is voluntary (without compensation) and can be terminated at the discretion of the MyCare Health Center Board of Directors. I am aware that I can be reimbursed for mileage for Board related activities. If chosen to be a Board member, I agree to abide by the policies, procedures, and rules of MyCare Health Center. I further agree to protect the confidentiality and privacy of any information regarding MyCare Health Center Board business and /or its patients.

Applicant Signature: _____ Date: _____

Please return this form to any MyCare location or mail to our administrative office at 6800 E. 10 Mile Road, Center Line, MI 48015