Thank you for your interest in the Kentucky Medicaid Beneficiary Advisory Council (BAC).

What is the Beneficiary Advisory Council (BAC)?

The BAC gives advice about Medicaid to the Cabinet for Health and Family Services and the Department for Medicaid Services. It is created by 42 CFR 431.12.

Who can be part of the BAC?

- People who are currently or have been enrolled in Medicaid.
- People with direct experience supporting those enrolled in Medicaid, such as parents, guardians, and paid or unpaid caregivers.

How does the BAC work?

There will be at least four BAC meetings each year. Meetings may be one to three hours long. Meetings will focus on Kentucky Medicaid services. The BAC must meet before the Medicaid Advisory Committee (MAC) meets. Seven (7) members of the BAC will also serve on the MAC.

How many members are on the BAC?

There will be fifteen (15) members appointed by the Commissioner of the Department for Medicaid Services.

How long does a member serve?

Members will be selected for a two-year, three-year, or four-year term when the BAC first starts to ensure member terms do not end at the same time. After that, future appointments will serve four-year terms. Individuals cannot serve back-to-back terms but could be reappointed four years after their term ends.

What else should I know?

Members will have the option to include their names in the membership list and meeting minutes to be posted publicly.

The Department for Medicaid Services will help members participate by providing support including but not limited to language services, personal assistance, and travel expenses.

If you are interested in serving on the BAC, you can submit an application through the following options:

1. Complete the on-line application here: ***KY Medicaid BAC Application***
2. Fill out this application and email it to **DMS.BAC@ky.gov**
3. Print and fill out this application and mail it to:
    - ***Kentucky Department for Medicaid Services***
    - ***ATTN: Beneficiary Advisory Council***
    - ***275 East Main Street, 2F***
    - ***Frankfort, KY 40621***

If you have questions or need help submitting your application, you can email DMS.BAC@ky.gov or phone 502-219-2170 for assistance.

Completing the application does not guarantee that you will be chosen for the council. Members will be appointed by the Commissioner of the Department for Medicaid Services.

Name:_____
Phone Number:_____
Email Address:_____
Street Address:_____
City, State and Zip Code:_____
County:_____

1. What is your experience with Kentucky Medicaid? (check all that apply)
   - ☐ Current Medicaid beneficiary
   - ☐ Former Medicaid beneficiary
   - ☐ Parent or guardian of a Medicaid beneficiary
   - ☐ Paid or unpaid caregiver of a Medicaid beneficiary

2. Some members of the Beneficiary Advisory Council will be appointed to the Medicaid Advisory Committee. Would you be interested in this option?
   - ☐ Yes
   - ☐ No

3. Why do you want to join the Beneficiary Advisory Council? You are welcome to share information on your interest in joining and experience, but it is not required. Please include anything you would like us to know below. (optional)

To make sure we have members who represent the different Kentucky Medicaid programs and populations, we are asking that you share information about yourself. The information requested below is optional and will remain private.

4. Please indicate your gender below:

   _____

5. With what racial/ethnic group do you most identify? We regret if the group most appropriate for you is not listed. If this is the case, please enter the group with which you identify.

   ☐ Asian or Pacific Islander ☐ African American (Black)

   ☐ Hispanic or Latino ☐ Native American or Alaska Native

   ☐ Caucasian (White)

   ☐ Other, enter other group here: _____

6. What is the primary language spoken in your home? _____
   - If English is not the primary language in your home, would you like interpretation services to assist your participation on the Beneficiary Advisory Council?

     ☐ Yes

     ☐ No

7. Are you in managed care (Aetna, Humana, Passport by Molina, United, WellCare)?

   ☐ Yes

   ☐ No

8. Which of the below apply to you or your family? Check all that apply:

☐ Foster care or former foster care

☐ Addiction Treatment, Substance use disorder services

☐ Long-Term Care services (home health, nursing facilities, PACE, hospice)

☐ Behavioral Health Services

☐ Justice Involved (juvenile justice or formerly incarcerated)

☐1915 (c) Home and Community Based Services Waivers, if checked, please choose which waiver below:

☐ Michelle P.

☐ Supports for Community Living (SCL)

☐ Acquired Brain Injury (ABI)

☐ Home and Community Based (HCB)

☐ Model II

☐ Acquired Brain Injury Long Term Care (ABI-LTC)

9. What is your age group?

☐ 18-21

☐ 22-30

☐ 31-45

☐ 46-65

☐ 66 and over

By submitting this application, you agree that the information in your application is true and accurate.

Signature: _____

Date: _____