California Department of Health Care Services
Home and Community Based Services (HCBS)
Advisory Workgroup Statement of Interest

1. Mr. ◯ Mrs. ◯ Ms. ◯

   First Name _____

   Last Name _____

2. Mailing Address _____

   _____

3. Phone number (____)_____

4. E-mail address _____

5. Individual Nomination

   Consumer ☐ Family Member ☐

   Provider ☐ *(Please I.d.)* _____

   Other ☐ *(Please I.d.)* _____

   Organization or Association Nomination ☐

   Please Identify _____

Note: *If you are nominated by an organization or association and are not the organization/association's Executive Director, your application must be accompanied by a letter from the Executive Director authorizing you to speak on behalf of the organization or association.*

California Department of Health Care Services
Home and Community Based Services (HCBS)
Advisory Workgroup Statement of Interest

1. In the space below, please describe the expertise and/or experience you will bring, in an advisory capacity, pertaining to the provision of transition services and population types in California. Please include participation on any related advisory bodies or waiver programs, if applicable.

2. In the space below, please describe what you hope to contribute as a result of participating on the HCBS Advisory Workgroup.

Applicant's Signature (personal assistant's signature is acceptable) ***Date***

Please send your completed application to Nichole Popovich at:

Nichole.popovich@dhcs.ca.gov