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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02258 (01/2018) | **STATE OF WISCONSIN**  Office of Policy and Practice Alignment |
| **MINORITY HEALTH ADVISORY COMMITTEE APPLICATION** | |
| The Division of Public Health (DPH) is seeking applications for membership on the Minority Health Advisory Committee (MHAC). The MHAC contributes to improving the overall health and well-being of racial and ethnic minority populations in Wisconsin. | |
| Membership is selected through a competitive application process. Members are eligible to serve two-year terms that are renewable for up to three (3) terms. | |
| **PURPOSE AND GOALS**   * Cultivate relationships/partnerships with ethnic minority communities. * Provide feedback regarding DPH initiatives, activities, and programs. * Assist with dissemination of information from DPH and Minority Health Program (MPH) to members’ respective communities. * Bring forth opportunities, challenges, and resources on behalf of your respective community and/or organization to the committee. * Participate in projects and/or tasks in smaller subcommittees as appropriate. | |
| **NOMINATION CRITERIA FOR ADVISORY COMMITTEE MEMBERSHIP**   * The committee will comprise a minimum of 10 and a maximum of 15 community members from across the state of Wisconsin, with at least one representative from each of the ethnic minority communities: African American, American Indian, Asian, and Hispanic. * Members will have strong expertise or interest in minority health and racial and/or ethnic health disparities. * Members can serve a maximum of two consecutive terms and may return for additional term(s) after being off the committee for one two-year term. * Members will meet quarterly each year. * Meeting locations will vary and travel may be required. * Members must be able to work with a diverse group of individuals. | |
| **SELECTION CRITERIA FOR ADVISORY COMMITTEE MEMBERSHIP**  The staff of the Minority Health Program will review the nominations and make recommendations to the DPH senior leadership. Senior leadership will make final appointments to the committee.   * Applications must be submitted to DPH through the [Minority Health Program mailbox](mailto:DHSWIMinorityHealthProgram@dhs.wisconsin.gov). * Potential members must apply. * New committee members will begin their terms in March 2018.   **Stipends will not be provided for participation on the Committee, but travel reimbursement can be arranged***.* | |

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| **MINORITY HEALTH ADVISORY COMMITTEE (MHAC) APPLICATION** | | | | | | | | |
| Name of Nominee | | | | | | | |
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| Organization (optional) | | | | | | | |
|  | | | | | | | |
| Address | | | City and Zip Code: | | | | |
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| Phone (Include area code) | | | | | Email Address | | |
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| Please below indicate how **you** identify **yourself.**  Note that the terminology used is from the Wisconsin Department of Health Services, and Wisconsin Minority Health Program, and may not reflect the terminology used by you and your organization(s). | | | | | | | |
| **Population/Sector** | | | | | | | |
| **Sex (Optional)** | Male | Female | | | | |  |
| **Ethnicity/Race** | American Indian | Black/African American | | | | | Hispanic |
| White | Asian | | | | | Other |
| **Population Representation** | | | | | | | |
| Please indicate **the interest** you will be representing in the MHAC. | | | | | | | |
| Will you be representing an organization on this committee? | | | | | | Yes  No | |
| What ethnic community does your organization represent? | | | | | |  | |
| What county is your organization located in? | | | | | |  | |
| Would you consider the community you represent urban or rural? | | | | | | Urban  Rural | |
| Are you an elected official? | | | | | | Yes  No | |
| Are you a part of Tribal or Local Health Department? | | | | | | Yes  No | |
| Do you participate in any other committees or boards concerning ethnic minorities in Wisconsin? | | | | | | Yes  No | |
| If selected for the committee, would you be interested in becoming an officer? | | | | | | Yes  No | |

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| **Short Answer Questions** |
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| **Please answer the following questions. You may answer below or provide your response in an attachment. (Maximum one page)** |
| 1. What are your experiences working with ethnic minorities whether volunteer or paid positions?   Click here to enter text. |
| 1. Why are you interested in being part of the committee?   Click here to enter text. |
| 1. What specific skills and knowledge can you contribute the committee?   Click here to enter text. |
| **Minority Health Advisory Committee Agreement** |
| If selected for membership in the Minority Health Advisory Committee, I commit to attending,  and actively participating in meetings and activities of the Committee during my term.  Yes  No |
| I have no conflict of interest with participation with The MHAC.  Yes  No |

**Nomination and Selection Process**

**Applications open** – January 16, 2018 (8:00 AM)

**Applications close** – February 5, 2018 (10:00 AM)

**Notification of selections** – February 13, 2018

**I have read and understand the requirements of becoming a member of the Minority Health Advisory Committee. If selected, I agree to adhere to the terms of this agreement.**

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| SIGNATURE - Nominee |  | | Date Signed |

Please submit applications to [DHSWIMinorityHealthProgram@dhs.wisconsin.gov](mailto:DHSWIMinorityHealthProgram@dhs.wisconsin.gov).

Applications submitted after **February 5, 2018 10:00AM** will not be considered.