Health Care for the Homeless Network
401 Fifth Avenue, Suite 1000
Seattle, WA 98104
206-263-8422 Fax 206-296-0184
TTY Relay: 711
www.kingcounty.gov/health

Health Care for the Homeless Network (HCHN)
GOVERNANCE COUNCIL MEMBERSHIP APPLICATION
(Consumer Representatives)

Note: This information will be shared only with Public Health – Seattle & King County staff and the HCHN Planning Council, which is providing the Public Health Department with guidance re: governing council membership. We will not release any of this information to other parties. Your information will help determine whether your interests are a good match for the Council at this time. We will not release any of this information to other parties.

Name ______________________________

Address

____

E-Mail ______________________________

Phone/Pager ______________________________

How can you best be reached during daytime, weekday hours? (By phone? Mail? E-mail?)

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Please tell us a little about your experience with homelessness and your experiences with the health care system (all information will be held confidential).

In your opinion, what are the biggest problems that homeless people face in getting access to health care that they need or want? Are there particular issues that concern you (for example, challenges with accessing primary medical care, dental care, mental health, substance abuse treatment, and care for a chronic disease, insurance coverage, etc.)

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How did you hear about Health Care for the Homeless Network?

To what extent have you used Health Care for the Homeless services (such as a nurse in a shelter or day center, an outreach worker, or a doctor or dentist at a clinic that serves people living homeless)?

We value all of your experiences. What other strengths, interests, and experiences can you share with the Council?

What is your race/ethnicity? What is your gender identity? What are your preferred pronouns?
(Note: if you are selected as a member, we must report your race, along with the race of all other members, in our federal grant applications).

I understand that the business of the Council will be conducted in a professional and respectful manner in regard to the confidentiality of consumers. I understand that my personal information will be held in confidence. I understand that in signing below, I am giving my permission for the Council to review my application.

____________________ ____
Date Signature of Applicant

The Council wishes to make it as easy as possible for you to apply for membership. We will be glad to help you fill out the application form and to answer any questions you may have about what it would be like to serve on the Council. Please call us. As there are only a limited number of seats on the Council, not every person who fills out an application form will be asked to serve on the Council.

Contact Persons:	Rekha Ravindran	(206) 263-6975
	John Gilvar, HCHN Program Manager	(206) 369-3489
Fax:	(206) 205-6236	
Address:	401 5th Ave, Suite 1000, Seattle, WA 98104	