SFHP Member Advisory Committee (MAC) Application

SAN FRANCISCO HEALTH PLAN™
Here for you

Fill out this form to join the MAC meetings starting in 2024.

First name:	Last name:
Address:	
Phone number:	Email:

Please choose the program you or a family member has:

☐ Medi-Cal ☐ Healthy Workers HMO ☐ Not an SFHP Member ☐ Other:

What language do you speak?

☐ English ☐ Spanish ☐ Chinese ☐ Other:

Please tell us why you want to join the MAC?

If you are not currently an SFHP member, please tell us more about you and your work with SFHP members and the San Francisco community.

Where do you work? (Optional for SFHP members)

Please describe your role, what you do, and how you work with SFHP members or the San Francisco community. (Optional for SFHP members)

SFHP Member Advisory Committee (MAC) Application

SAN FRANCISCO HEALTH PLAN™
Here for you

Sign your name to agree.

I want to join the MAC. I agree to attend four MAC meetings in-person a year. I will share my ideas and concerns at each meeting. My feedback helps SFHP provide good care for members.

_____ _____

Signature Date

You can mail this application to:

San Francisco Health Plan
P.O. Box 194247
San Francisco, CA 94119

Or you can email this application to: **MAC_Application@sfhp.org**