SFHP Member Advisory Committee (MAC) Application

San Francisco Health Plan

Fill out this form to join the MAC meetings starting in 2026.

First name: | Last name:

Address: | Date of Birth:

Phone number: | Email: | SFHP ID#:

Please choose the program you or a family member has: ☐ Medi-Cal ☐ Medicare ☐ Healthy Workers HMO
☐ Not an SFHP Member ☐ Caretaker of SFHP Member ☐ Other, please specify:

Please check all that apply to you:
☐ Parent of children and adolescents ☐ Parent/caregivers of foster youth ☐ Caregiver of parent who is an SFHP Member

What are your pronouns?
☐ He/him ☐ She/her ☐ They/them ☐ Other, please specify: ☐ Choose not to disclose

What is your gender?
☐ Male ☐ Female ☐ They/them ☐ Transgender male/trans man/female-to-male (FTM)
☐ Transgender female/trans woman/male-to-female (MTF) ☐ Genderqueer, neither exclusively male nor female
☐ Additional gender category or other, please specify: ☐ Choose not to disclose

What is your race? (check all that apply)
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan

Are you of Hispanic, Latino, or Spanish origin? (optional)
☐ Yes ☐ No

If yes, please specify:
☐ Mexican, Mexican American, Chicano ☐ Salvadoran
☐ Cuban ☐ Guatemalan ☐ Puerto Rican
☐ Other Hispanic, Latino, or Spanish origin, please specify:

Do you have a physical, mental, emotional or developmental disability? ☐ Yes ☐ No

Do you need help with long-term care or home and community-based services? ☐ Yes ☐ No

Do you require materials in any of the following formats?
☐ Braille ☐ Large Print ☐ Audio Electronic Format ☐ Data Electronic Format
☐ Translation, add preferred language:

SFHP members only: Please tell us why you would like to join the Member Advisory Committee (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)

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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**