Patient and Family Advisory Council Application

Thank you for your interest in the Corner Health Center's Patient and Family Advisory Council (PFAC)! The purpose of PFAC is to be a mechanism for dialogue between patients, patient families, and medical professionals ensuring that the Corner Health Center provides exemplary patient care.

As a member of the PFAC, you would get to share your opinions on all kinds of factors that affect patient care.

The PFAC will use information and feedback collected from the Patient Satisfaction Survey as well as input from PFAC council members to guide the council's goals and initiatives.

Qualifications:

- All applicants must be current patients at the Corner Health Center or have a child who is a patient at the Corner Health Center. This means you or your child must have been to the Corner for an appointment at least once in the past year.
- Applicants must have a reliable method of transportation or be willing to make reasonable transportation accommodations through CHC in order to come to regularly scheduled meetings.

Responsibilities:

All applicants must be able to attend an introductory meeting on October 7, 2019 at 5:30pm and each of the four quarterly meetings throughout the rest of the year. The regular meetings will last roughly an hour and will take place every three months here at the Corner. These meetings will be scheduled at the introductory meeting.

Incentives:

- Meals provided at each meeting.
- $10 payment for each meeting attended.
- Childcare at each meeting.

All applicants must be committed to improving care at the Corner Health Center. We want to hear from you! Please come prepared to share your thoughts, opinions, and ideas.

Applications are due by September 20th, 2019

Corner Health Center

Patient and Family Advisory Council Application

All information provided will be kept confidential. The information you write here will help us select a council with a broad range of interactions with the Corner Health Center's services.

Application must be filled out in its entirety. Failure to do so will void your application.

PLEASE PRINT

First Name Last Name Middle Initial

If you have used other names in the past, please list them:

Address: Number Street City State Zip Code

Telephone Number(s): Home Cell Work

Email

Preferred method of contact

What types of services have you or your child/children used at the Corner? Circle all that apply:

Care Management (help finding and/or applying for resources like health insurance, housing, SNAP, or WIC)

Groups (Summer Series, Transgender Support Group, Healthy Youth Healthy Futures, Mom Power, SOAR)

Theatre Troupe

Nutrition

Prenatal Care

Psychiatry

Regular check-ups (well child exams, annual exams, physicals)

Youth Leadership Council

Sexual Healthcare (STI testing/treatment, pregnancy tests, contraception)

Therapy/Counseling

Transgender services

Other: ____________

the CORNER Health Center

Why would you like to be on the Patient and Family Advisory Council?

What concerns would you like to see the Patient and Family Advisory Council address?
Would you bring any young children to meetings that need childcare? How many?
Do you have a reliable way to get to the Corner for meetings?
Would you be interested in being a council patient chair? This is a leadership position open to patients who have the time and desire to help plan and run PFAC meetings. The patient chair will be voted on at the introductory PFAC meeting in October, but we need to know now whether you're interested.
Is there anything else you would like us to know?

Signature Date

PLEASE RETURN APPLICATION TO THE FRONT DESK AT THE CORNER HEALTH CENTER