



## **Texas Health and Human Services Commission Application for Advisory Committee Membership**

If you wish to apply to be a member of the **Hospital Payment Advisory Committee**, please fill out this application. The **Hospital Payment Advisory Committee** functions as a subcommittee of the Medical Care Advisory Committee. It advises the MCAC and HHSC on changes to hospital payment methodologies for prospective inpatient hospital payments. The committee also advises on adjustments for disproportionate share hospitals to ensure reasonable, adequate, and equitable payments to hospital providers and to address the essential role of rural hospitals.

If a question does not apply to you, enter "N/A."

Please attach a resumé using the "attach file" button below.

HHSC will use the information you put on this application and your resumé to decide if you are eligible to serve on this committee.

*Important note: Committee members are reimbursed for their travel to and from meetings if funds are available.*

**HHSC won't consider an application received after 11:59 pm  
Jan. 12, 2018.**

**SECTION 1 - Personal Information**

Name:

Home Address:

City: State: TX ZIP:

Phone: Fax: Email:

**Employment Information**

Business/Organization:

Address:

City: State: ZIP:

Phone: Fax: Email:

Current Position Title:

**Check where you would like to receive further communications:**

Work Email Home Email Work Address Home Address

*Application*

New/Initial Application

Renewal Application

*Gender*

Male

Female

*Race/Ethnicity*

American Indian/Alaskan Native

Asian/Pacific Islander

Black

Hispanic

White

Other

**SECTION 2 Applicants**

**Per Texas Government Code §533.041(a), applicants may fall into the categories below. Please check the category you would like to apply for. You may select more than one category that applies to you.**

Provider

Professional association

Non-profit organization

Managed care organizations

Subject matter expert involved in hospital payment issues

**Describe your direct knowledge of the publicly funded hospital systems serving low income individuals with and without insurance.**

**Explain why you are interested in serving on this committee.**

**List your relevant personal and professional achievements, including current licensures and activities that address contributions you could make to the committee:**

**Have you ever been disciplined by any licensing board or professional or civic organization, including the HHSC Inspector General?**

**No            Yes**

If yes, please explain:

**SECTION 3**

**The HHS executive commissioner will appoint three members to the committee to serve terms expiring Dec. 31, 2023. The new members must must have experience with hospital payment systems as the committee is responsible for advising the HHS executive commissioner on matters necessary to ensure reasonable, adequate and equitable payments to hospital providers and to address the essential role of rural hospitals.**

I affirm that I meet the above requirements.

**Member Participation**

Every member appointed to the committee must attend regularly.

- Regular committee meetings are held about once every three months. The presiding officer also may call a special committee meeting. Members must travel to Austin for these meetings. Each meeting may last several hours.
- Sometimes, members participate in other activities in their home communities. These activities might include town hall meetings or presentations.
- Please note: Committee members are reimbursed for their travel to and from meetings.

**Do you believe you will be able to regularly participate in committee activities, if you are appointed?**

**No            Yes**

If no, please explain:

**Have you served, or are you currently serving, on other advisory committees, councils or workgroups? If so, please list the name of the group, its charge and your role.**

**Miscellaneous Information**

**Do you have a personal or private interest in a matter pending before HHSC?** ("Personal or private interest" means you have a direct monetary interest in the matter or owe your loyalty to an entity involved, but does not include the member's engagement in a profession, trade or occupation when the member's interest is the same as all others similarly engaged in the profession, trade or occupation.)

**No            Yes**

**Have you ever been convicted of a felony or misdemeanor (excluding traffic violations)?**

**No      Yes**

If yes, please explain:

**References**

Please provide the names and contact information for two people who can tell us more about your qualifications to serve on the committee.

References can include employers, clients, religious leaders, community leaders, advocates, friends or others who know about your interest in and/or involvement with service delivery through Medicaid.

**Reference #1**

Name:

Address:

City:

State:

ZIP:

Daytime Phone:

Email:

Relationship (how this person knows you):

**Reference #2**

Name:

Address:

City:                      State:      ZIP:

Daytime Phone:

Email:

Relationship (how this person knows you):

**All the information contained in this application is true and correct. I understand that the advisory committee will meet in Austin at least quarterly. If selected, I will make every effort to attend all advisory committee meetings.**

\_\_\_\_\_  
Signature (electronic or typed name is acceptable)                      *Date*

**While it is preferred that you submit your application electronically, using the SUBMIT button, you may submit the application by email, mail or fax. Here are the addresses:**

*Email: [charles.bredwell@hhsc.state.tx.us](mailto:charles.bredwell@hhsc.state.tx.us)*

*Mail: Texas Health and Human Services Commission  
P.O. Box 13247, Mail Code H600  
Austin, Texas 78711  
Attn: Charles Bredwell*

*Fax: 512-487-3403  
Attn: Charles Bredwell*

If you have any questions about the application, please contact Charles Bredwell at 512-462-6337 or by email at [Charles.Bredwell@hhsc.state.tx.us](mailto:Charles.Bredwell@hhsc.state.tx.us).

If you have questions about the Hospital Payment Advisory Committee please contact Dana Williamson at [Dana.Williamson@hhsc.state.tx.us](mailto:Dana.Williamson@hhsc.state.tx.us).

**You will receive confirmation that your application has been received within two business days of receipt. If you do not receive this confirmation, please contact Charles Bredwell at [charles.bredwell@hhsc.state.tx.us](mailto:charles.bredwell@hhsc.state.tx.us).**