

WV I/DD Waiver Quality Improvement Advisory Council Membership Application

Type of Representation on the Council (please check one)		
<input type="checkbox"/> Current or former program Member/Legal Representative/Family Member	<input type="checkbox"/> Stakeholder (family, community member, advocate of persons with I/DD)	<input type="checkbox"/> I/DD Waiver Provider
Applicant Information		
Name:		Phone Number:
Address:	City, County, Zip Code:	Email:
Please provide a brief description of your experience in the field of disabilities and the I/DD Waiver Program		
Why would you like to serve on the QIA Council?		
Tell us about your involvement and/or advocacy experiences with other organization, boards, or groups.		
Please provide the names of two people that we may contact as references.		
Reference #1 Name	Daytime Phone Number	How the person knows you
Reference #2 Name	Daytime Phone Number	How the person knows you
Certification/Signature		
<input type="checkbox"/> I certify that I am willing and able to attend/participate in person/virtually in quarterly meetings of the QIA Council.		
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Applicant Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date	
Application Submission		
Please submit membership application to Acentra Health via email (wviddwaiver@acentra.com) or fax (866-521-6882). Thank you for applying to the I/DDW QIA Council.		