



**Kansas Maternal & Child Health Council (KMCHC)  
Consumer/Family Member Application**

Effective Date: July 1, 2016

*Thank you for your interest in the Kansas Maternal & Child Health Council!*

The mission of Kansas Maternal and Child Health (MCH) is to improve the health and well-being of Kansas mothers, infants, children, and youth, including children and youth with special health care needs (SHCN), and their families. We envision a state where all are healthy and thriving.

The Kansas Maternal and Child Health Council (KMCHC) was formed as a state-level group to advise and monitor progress addressing specific MCH population needs. The Council encourages the exchange of information about women, infants, children, and adolescents, and helps focus efforts among partners which include consumers/families and recommends collaborative initiatives. For additional information regarding the KMCHC, please refer to the guiding documents: Code of Ethics and Professional Conduct, Bylaws, and Reimbursement Policy available on the website: [www.kansasmch.org](http://www.kansasmch.org).

Name		Address	
Preferred Phone		City, State Zip:	
Email Address			
Preferred method of communication	<input type="checkbox"/> Email <input type="checkbox"/> Phone Call <input type="checkbox"/> Text		
Primary Expertise/Role	<input type="checkbox"/> Consumer/Patient <input type="checkbox"/> Parent <input type="checkbox"/> Family Member		
If Parent, # of children and ages			
MCH Population Domain* most interested in advising	<input type="checkbox"/> Women/Maternal <input type="checkbox"/> Perinatal/Infant <input type="checkbox"/> Child <input type="checkbox"/> Adolescent <small>*All domain groups are responsible for addressing Children &amp; Youth with Special Health Care Needs and Cross-cutting population priorities and issues.</small>		
Check all that apply related to your role/experience with the <b>Special Health Care Needs</b> population. <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____			

Please check the public health program(s) from which you have experience and/or received services. (NOTE: It is okay if you have not received services!)

- |  |   |
|--|---|
| <input type="checkbox"/> Newborn Screening                 | <input type="checkbox"/> Newborn Hearing Screening        |
| <input type="checkbox"/> Infant-Toddler Services (ITS)     | <input type="checkbox"/> Special Health Care Needs (SHCN) |
| <input type="checkbox"/> Maternal & Child Health (MCH)     | <input type="checkbox"/> Home Visiting                    |
| <input type="checkbox"/> Women, Infants and Children (WIC) | <input type="checkbox"/> Other(s) _____                   |



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*Please briefly respond to the following questions in the spaces provided.*

Why are you interested in participating on the Kansas MCH Council?
In what ways have you shown leadership/been involved in your community?
How do you best communicate with other team members?
The Kansas MCH Council is not designed to be very time intensive (one meeting every 2-3 months with minimal review of documents outside of meetings); however, a commitment to active participation is necessary. The primary method of communicating with members is through email.  Please provide any reason that you may have a difficult time participating in meetings.  <input type="checkbox"/> I do not anticipate having difficulties in participating in meetings or activities.  <input type="checkbox"/> I anticipate having difficulties in participating in meetings or activities. (Please describe accommodations that are needed to support your participation.)
Please provide any additional information that may be helpful to us in our selection process.

Thank you for taking the time to complete this application to participate as a member of the Kansas Maternal & Child Health Council. All information on this form is considered confidential and is intended for use by the KDHE Administrative Staff for selection purposes only. We will contact you by email to inform you of our decision.

Please submit the application by email or mail. Questions can be referred to Rachel Sisson at 785.296.1310 or [rachel.sisson@ks.gov](mailto:rachel.sisson@ks.gov).

Email: [rachel.sisson@ks.gov](mailto:rachel.sisson@ks.gov)  
Mail: Rachel Sisson, Kansas MCH Director  
Kansas Department of Health & Environment  
Bureau of Family Health  
1000 SW Jackson Ave., Suite 220  
Topeka, KS 66612

<b>Office Use Only</b>
Appointment Recommendation: ____ Yes ____ No ____ Hold for future placement
Comments: