Washington State Health Care Authority

Community member application and attestation form

Thank you for participating in a Health Care Authority (HCA) board, committee, or similar Class One Group (a Class One Group is also called a workgroup)! Your contributions and insights are vital to our work together as we shape equitable and community-centered solutions. We deeply value your expertise, which is vital to building a system that supports the health and wellbeing of all Washington residents.

The purpose of this document is to:

- Collect information to understand who participates in our workgroups and ensure representation across Washington communities.
- Provide information so you can determine if you are eligible to receive a stipend for your participation.

Important: We are required to share workgroup-related data with the Washington State Office of Equity for reporting purpose. **Learn more**.

1 Contact information

Name

Phone number

Email

In what Washington state county do you reside? (If you do not have a permanent address, please list the county where you spend most of your time.)

Name of HCA board, commission, council, committee, or similar group

What is the best way to communicate with you? Check all that apply.

- [ ] Email
- [ ] Text message
- [ ] Phone
- [ ] In person
- [ ] Other

2 Participation details

We sincerely thank you for your participation! What interests you in serving in this group?

Please describe your participation:

Community member

I'm participating on behalf of an individual, community, or organization

Please describe your general availability for participating (e.g., hours per month). This could include preference for virtual meetings, only available nights/weekends, etc.

I identify as a person with a disability

How can HCA best support you and your participation in this workgroup?

Do you need language access services to participate?

Yes No

If yes:

Closed captions (Communication Access Real-time Transcription (CART) services)

Large print

Spoken language interpreter

Sign language interpreter

Braille

Translation

Enter preferred language access service:

Other,

Enter details:

3 Demographic and other information

The following questions are optional. Your response will help us ensure representation across the communities we serve in Washington.

Race (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ White or Caucasian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Prefer not to say

Ethnicity

- ☐ Hispanic or Latino/a/e/x
- ☐ Not Hispanic or Latino/a/e/x
- ☐ Prefer not to say
- ☐ Prefer to self-describe, enter description:

Which language(s) are you fluent or proficient in? Check all that apply.

- ☐ Cambodian
- ☐ Chinese
- ☐ English
- ☐ Korean
- ☐ Laotian
- ☐ Russian
- ☐ Somali
- ☐ Spanish
- ☐ Vietnamese
- ☐ Prefer not to say
- ☐ Other

What gender category best describes you?

- ☐ Female
- ☐ Male
- ☐ Gender non-conforming
- ☐ Prefer to self-describe, enter description:
- ☐ Non-binary
- ☐ Two-Spirit
- ☐ Prefer not to say

What are your preferred pronouns? (she/her, he/him, they/them, etc.)

Enter preferred pronouns: ☐ Prefer not to say

What age range are you in? Select the box that best applies.

- ☐ Youth up to age 18,

  I have permission from my parent or legal guardian to participate: ☐ Yes ☐ No
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44

45-54

55-64

65 + and up

Do you have current or prior military experience?

Yes

No

4 Determining stipend eligibility

We offer stipends and other reimbursements to reduce financial barriers to your participation, which can lead to more equitable and sustainable health outcomes.

Note: Stipends are provided to support those with lived/living experience. If you are participating in an official capacity for an organization and receive separate compensation for this work, you are not eligible.

Eligible community members may receive a stipend at the following rates, not to exceed $200 in a single day:

- **1 hour or less = $57.00**
- **2 hours or more than 1 hour = $114.00**
- **3 hours or more than 2 hours = $171.00**
- **3+ hours = $200.00**

5 Determining low-income status

If your income is at or below 400% of the Federal Poverty Level (FPL), you qualify as low-income. See the table below or view the **U.S. Health and Human Services' guidance**.

2025 FPL guidelines

Person(s) in family/ household	1	2	3	4	5	6	7
400% FPL	$62.600	$84,600	$106,600	$128,600	$150,600	$172,600	194,600

Person(s) in family/ household	8	9	10	11	12	13	14
400% FPL	$216,600	$238,600	$260,600	$82,600	$304,600	$326,600	$348,600

Do you have a low-income status, based on the above table?

Yes, I qualify as low income

No, I don't qualify

Do you have direct lived/living experience in the subject matter?

Yes

No

Are you otherwise compensated for workgroup activities?

Yes

No

Are you eligible to receive the stipend?

☐ Yes, I have direct lived experience and/or qualify as low-income and am not otherwise compensated

☐ No, I am not eligible

Statewide Vendor Number

Check the box that best applies.

☐ I agree to request a **Statewide Vendor Number (SWN)** from the Washington Office of Financial Management to receive payment from HCA. An SWN is required for ongoing receipt of compensation from HCA beyond a single workgroup. Participating in ongoing work without a SWN may result in payment delay or ineligibility

☐ I already have an SWN. My SWN is:

☐ I don't need an SWN because I'm not eligible for the stipend

Compensation & benefits

Stipends are considered taxable income. Please consider whether a change in your income (in the current calendar year) could affect your health benefits. This includes food assistance, housing assistance, or other financial impacts. Certain benefit programs are impacted by stipends and reimbursements. View the program list in the **Community Compensation Guidelines**. If you don't find your benefit program listed or are unsure how stipends may affect your benefits, please contact the agency responsible for issuing those benefits.

Public Records Act & public disclosure

Please be aware that the work of any state or local government agency is subject to the requirements of the Public Records Act (PRA), RCW 42.56. This means that all records created, owned, used or maintained in the conduct of HCA business must be provided upon request and are subject to release under the PRA, unless there is a specific legal exemption that applies. This includes records, such as emails from participating workgroup community members to a workgroup lead, co-lead, or other HCA staff member, as well as any attached documents.

6 Signature

I, (name), acknowledge that I serve voluntarily on the (workgroup name) for the Washington State Health Care Authority and have accurately attested to my eligibility or ineligibility to receive a stipend.

First and last name

Signature

Date signed

Please email or directly mail this form to HCA.

Email
Please complete this form and email to your workgroup lead, and cc HCA's Accounting Office at: **traveldesk@hca.wa.gov**.

Mail
Washington State Health Care Authority
Regarding: Community member stipends
Attention: Accounting Office and your workgroup lead
P.O. Box 45502
Olympia, WA 98504-5502