

**Disability Rights IOWA
400 East Court Avenue
Suite 300
Des Moines IA 50309**

**PHONE: (515) 278-2502 or (800) 779-2502 FAX: (515) 278-0539
TTY: (515) 278-0571 or (866) 483-3342**

APPLICATION FOR THE PAIMI ADVISORY COUNCIL

(Please type or print the information requested below.)

NAME: _____ PHONE (____) _____

HOME ADDRESS: _____
(Street) (City) (State) (Zip Code)

BUSINESS NAME: _____ PHONE (____) _____

BUSINESS ADDRESS: _____
(Street) (City) (State) (Zip Code)

Please send postal mail to my Home Business

Email Address for sending correspondence: _____

Please check the area in which you live: Rural/outside city limits, in town,
less than 5,000 population, In town, 5,001-15,000, In town, over 15,000

How did you hear about Disability Rights IOWA?

Check all the categories that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Individual who receives
or has received mental
health services | <input type="checkbox"/> Attorney |
| <input type="checkbox"/> Family member of a person
who receives or has received
mental health services | <input type="checkbox"/> Mental Health Professional |
| <input type="checkbox"/> Mental Health Service Provider | <input type="checkbox"/> Person who is interested in and
knowledgeable about mental
health services |

Are you a member of a minority group or represent diversity? Yes No

Prefer not to answer. If yes, please specify:

(Over)

Background, involvement or reasons for interest in serving individual's with mental illness. :

Please list events/areas that you have advocated for yourself or someone else related to mental illness: (i.e. education, employment, housing, abuse or neglect, receiving benefits or adequate services, etc.)

Please list current or previous organization affiliations, boards, or commissions, including any offices held. Please include your length of service and term expiration date:

Please list your educational background and/or training received that relates to mental illness, advocacy, or leadership:

Please list current or previous employment, titles, etc. and if you work with individuals with disabilities or mental illness in any way:

ON A SEPARATE SHEET, PLEASE LIST ANY OTHER COMMENTS YOU WISH TO MAKE ABOUT YOURSELF, WHY YOU ARE INTERESTED IN SERVING ON THE DISABILITY RIGHTS IOWA PAIMI ADVISORY COUNCIL AND YOUR PHILOSOPHY ON ADVOCACY SERVICES FOR PEOPLE WITH MENTAL ILLNESSES.

Members must make every effort to attend all meetings in person or with accommodation. Mileage and meal reimbursement will be provided by Disability Rights Iowa when attending the meetings. The PAIMI Advisory Council meets three times a year, with meetings held on Saturday mornings. Additional time commitments may include project/ committee work, related meetings, etc.

Signature _____ Date Completed _____
(Applications will be kept on file for two years.)