

**Application for Benton County
Mental Health Advisory Council**

Name: _____
Phone: (Home) _____ (Work) _____
Home Address: _____
Email Address: _____

Please identify yourself as representing one or more of the following categories; check all that are appropriate:

- _____ Mental Health Consumer as an Adult
- _____ Mental Health Consumer as a Child/Adolescent
- _____ Family Member of an Adult with Mental Illness
- _____ Parent of a Child/Adolescent with Severe Emotional Disturbance
- _____ Adult Mental Health Professional. Note the program you represent:

- _____ Children's Mental Health Professional. Note the program you represent:

- _____ Adult Community Support Services Program Representative. Note the program you represent: _____
- _____ Family Community Support Services Program Representative. Note the program you represent: _____
- _____ Children's Local System of Care Coordinating Council Representative.
- _____ Minority Population Representative
- _____ Other: (Please specify) _____

What qualities or qualifications do you have that support your application to serve on this Advisory Council? (Please consider your personal experiences, work experiences, educational experiences, ability to work with a group, community work, ability to look at the entire system, and anything else you think may be important. Attach extra page(s) if you wish.)

I, the undersigned, hereby state that I will be able, to the best of my knowledge, to attend meetings and participate in the activities of the Mental Health Advisory Council.

Signature of Applicant

Date

If applicant is being nominated by another person or group, the above signature indicates consent to nomination.