Recipient Rights Advisory / Appeals Committee

MEMBERSHIP APPLICATION

NAME: ____

ADDRESS: ____

CITY, STATE, ZIP: ____

PRIMARY PHONE (S): ____

EMAIL: ____

Preferred method of correspondence: ☐ Email ☐ USPS Mail ☐ Phone/ Voicemail

PLEASE RETURN YOUR COMPLETED APPLICATION BY FAX, MAIL, OR EMAIL TO:

North Country Community Mental Health
Office of Recipient Rights
1420 Plaza Drive
Petoskey, MI 49770
Fax: 231-439-8752
Email: krappleyea@norcocmh.org

Applications will be forwarded to the NCCMH Board of Directors for consideration and appointment.

The NCCMH Board will not discriminate against any individual or group because of race, sex, religion, national origin, color, marital status, handicap, or political beliefs. Auxiliary aid and services are available upon request to individuals with disabilities.

1. Which of the following categories *best* describes you?

☐ **"Primary Consumer"** An individual who has received or is receiving services from the department (MDHHS) or a community mental health services program or services from the private sector equivalent to those offered by the department or a community mental health services program.

☐ **"Family Member"** A parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer, or an individual upon whom a primary consumer is dependent for at least 50% of his or her financial support.

☐ **"Member at Large"** An individual who demonstrates an interest and a commitment to promoting and protecting the rights of individuals with disabilities who receive services supported by NCCMH.

2. Briefly explain your category choice:

3. Which of the following populations, if any, would you best be able to represent? (Choose all that apply)

☐ Adults with Serious Mental Illness

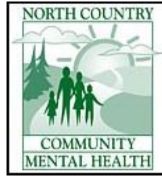
☐ Adults with Developmental/Intellectual Disability

☐ Children with Developmental Disability

☐ Children with Severe Emotional Disturbance

☐ N/A

4. Briefly explain why you are interested in becoming a member of the Recipient Rights Advisory/ Appeals Committee:



5. Please list any special experience, resources, and/or knowledge you will bring to the committees:

6. Do you have any conflicts of interest that would prevent you from serving on the committees?

☐ No ☐ Yes (Please explain)

7. Will you be able to attend all scheduled meetings?

☐ Yes ☐ No (Please explain)

8. Do you need any special accommodations to assist you in serving on the committees?

☐ No ☐ Yes (Please explain)

I understand that this application will be shared with the NCCMH Board of Directors to review information necessary for the appointment of the Recipient Rights Advisory/ Appeals Committee. The information will not be made public. I further agree, if appointed, to permit my name to be added to the committee membership list. I understand that this list is available to any individual upon request but that it will not include any confidential information.

Signature: ____ Date: _____________

Printed Name: ____

Thank you for your interest in serving on the Recipient Rights Advisory/Appeals Committee!

7/2018