



# Application for Membership

If you are selected to serve on the ABHPAC, the information on this form will be distributed within the Division of Behavioral Health Services and could be released to the public. For your application to be considered, you must complete the items indicated on this form.

**Date:** [Click here to enter a date.](#)

<b>Full Name:</b>	Click here to enter text.
<b>Mailing Address:</b>	Click here to enter text.
<b>City, State, Zip:</b>	Click here to enter text.
<b>Cell Phone:</b>	Click here to enter text.
<b>Home Phone:</b>	Click here to enter text.
<b>Other Phone:</b>	Click here to enter text.
<b>Email Address:</b>	Click here to enter text.

If you prefer information sent by regular mail check this block

**Affiliations:** Federal law requires certain groups be represented on the planning and advisory council. Please check all the following groups that apply to you in order to keep accurate records of compliance.

Yes <input type="checkbox"/>	I am currently a provider of behavioral health services.
Yes <input type="checkbox"/>	I work for or represent (e.g. board member, volunteer, etc.) an organization that is “concerned with the need, planning, operation funding, and use of behavioral health services and related support service”
Public <input type="checkbox"/> Private <input type="checkbox"/>	If you do work or represent an organization that is described above is it
Yes <input type="checkbox"/>	I am currently an employee for the State of Arkansas. This state agency focus is with: <input type="checkbox"/> Mental Health <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Education <input type="checkbox"/> Housing <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Social Services <input type="checkbox"/> None of the above

**Personal Identification(s), Interest(s), Skill Areas:**

Federal law requires that certain consumer and family groups be represented on the Planning and Advisory Council. In addition to meeting the requirements, we want to include as many consumer representatives as possible.

Many members fit into more than one of the categories listed below. Certain roles or slots within the Council require identification as a consumer or family member. You are free to leave any statements unanswered. However, this information is used in processing the application and determining eligibility of roles that can be held within the Council.

Yes <input type="checkbox"/>	A member of my family has or had a psychiatric or substance abuse diagnosis.
Yes <input type="checkbox"/>	I am willing to be identified as a “family member” of a person identified as a consumer/survivor.
Yes <input type="checkbox"/>	I have a child or youth who has or had a psychiatric or substance abuse diagnosis.
Yes <input type="checkbox"/>	I am willing to be identified as a “parent of a consumer” or as a “consumer/survivor”.
Yes <input type="checkbox"/>	In my lifetime, I have personally received mental health services.
Yes <input type="checkbox"/>	I am willing to be identified as a “consumer”.
Yes <input type="checkbox"/>	In my lifetime, I have personally received substance abuse services.
Yes <input type="checkbox"/>	I am willing to be identified as a “client”.

**I have a particular interest in working on the Behavioral Health issues for:**

<input type="checkbox"/>	Children	<input type="checkbox"/>	Adults	<input type="checkbox"/>	Both Groups
<input type="checkbox"/>	Addiction/Substance Abuse	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	Co-Occurring Issues

Please share any experience you have had working with committees or groups such as PTA, church committees, scouts, or at work etc. Note any leadership roles you held.

Click here to enter text.

If there is additional information or comments you feel would be useful to the Selection Committee considering your application for membership please add it below.

Click here to enter text.

**The ABHPAC is committed to maximizing the diversity of its membership.**

Reimbursement for expenses incurred to make your participation possible may be available. Reasonable accommodation for disabilities is provided. Contact information is listed below to request accommodations or reimbursements.

**ABHPAC**

DBHS/Rebecca Webber  
4800 West 7<sup>th</sup> Street  
Little Rock, AR 72205  
501-686-9164

Email: [rebecca.webber@arkansas.com](mailto:rebecca.webber@arkansas.com) or Fax to 501-686-9182