



**APPLICATION FOR THE  
MENTAL ILLNESS  
ADVISORY COUNCIL**

State Form 54271 (R3 / 9-17)



INDIANA  
**DISABILITY RIGHTS**

4701 North Keystone Avenue, Suite 222  
Indianapolis, IN 46205  
Telephone: (317) 722-5555 or (800) 622-4845  
TTY number: (800) 838-1131  
Fax number: (317) 722-5564  
**E-mail address:**  
[executivedirector@indianadisabilityrights.org](mailto:executivedirector@indianadisabilityrights.org)

*Please type or print and complete this questionnaire to the best of your ability. Mail, fax, drop-off or e-mail the completed application to the above address. In accordance with state law, any information you provide will become a matter of public record. Applications will be kept on file for six (6) months.*

*Federal regulations [42 CFR Part 51.23(b)] contain requirements prescribing the background of those who serve on the Mental Illness Advisory Council.*

Name		Telephone number (    )
Home address (number and street, city, state and ZIP code)		
Occupation	Name of employer	
Business address (number and street, city, state and ZIP code)		
Please send postal mail to my: <input type="checkbox"/> Home <input type="checkbox"/> Business		E-mail address
What is the best way to contact you? (Check one.) <input type="checkbox"/> Mail <input type="checkbox"/> Telephone <input type="checkbox"/> E-mail		
How did you learn of this opportunity?		

*Please check **all** of the categories that apply to you.*

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

**Optional:** To acquire the best possible understanding of your background and interests, we encourage you to include a copy of your resume and/or a cover letter. Should you choose to submit a cover letter, please describe why you are interested in serving on the Indiana Disability Rights Mental Illness Advisory Council and your philosophy on advocacy services for people with mental illness.

*Please note: If you would like assistance completing this application, please contact Indiana Disability Rights at 800-622-4845.*

**In order to achieve diversity and comprehensive representation of the Indiana Disability Rights Mental Illness Advisory Council, we would appreciate your response to the following:**

<p>Are you a member of a minority group or represent diversity within the mental health community?  <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> Prefer not to answer</p>		
<p><i>If yes, please specify.</i></p>		
<p>Please identify all languages in which you are proficient.  <input type="checkbox"/> English    <input type="checkbox"/> Spanish    <input type="checkbox"/> American Sign Language (ASL)    <input type="checkbox"/> Burmese  <input type="checkbox"/> Other (<i>specify</i>): _____</p>		
<p>Do you have experience as a member of or working with other cultures (ex: Deaf culture, Hispanic culture, etc.)?  <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> Prefer not to answer</p>		
<p><i>If yes, please specify.</i></p>		
<p>Please identify areas in which you have advocacy experience. (<i>Please check all that apply.</i>)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Abuse / Neglect / Exploitation  <input type="checkbox"/> Access to Services / Programs  <input type="checkbox"/> Advocacy  <input type="checkbox"/> Assistive Technology  <input type="checkbox"/> Autism  <input type="checkbox"/> Centers for Independent Living  <input type="checkbox"/> Community Relations Programs  <input type="checkbox"/> Corrections Programs  <input type="checkbox"/> Dual Diagnoses – MI / Intellectual Disability  <input type="checkbox"/> Dual Diagnoses – MI / Substance Abuse  <input type="checkbox"/> Employment             </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Higher Education  <input type="checkbox"/> Housing  <input type="checkbox"/> Pharmacology  <input type="checkbox"/> Residential Care Facilities  <input type="checkbox"/> Restraint / Seclusion  <input type="checkbox"/> Self-Advocacy  <input type="checkbox"/> Special Education  <input type="checkbox"/> State Institutions  <input type="checkbox"/> Veterans Affairs  <input type="checkbox"/> Vocational Rehabilitation  <input type="checkbox"/> Other: _____             </td> </tr> </table>	<input type="checkbox"/> Abuse / Neglect / Exploitation <input type="checkbox"/> Access to Services / Programs <input type="checkbox"/> Advocacy <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Autism <input type="checkbox"/> Centers for Independent Living <input type="checkbox"/> Community Relations Programs <input type="checkbox"/> Corrections Programs <input type="checkbox"/> Dual Diagnoses – MI / Intellectual Disability <input type="checkbox"/> Dual Diagnoses – MI / Substance Abuse <input type="checkbox"/> Employment	<input type="checkbox"/> Higher Education <input type="checkbox"/> Housing <input type="checkbox"/> Pharmacology <input type="checkbox"/> Residential Care Facilities <input type="checkbox"/> Restraint / Seclusion <input type="checkbox"/> Self-Advocacy <input type="checkbox"/> Special Education <input type="checkbox"/> State Institutions <input type="checkbox"/> Veterans Affairs <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Other: _____
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<p>What are you currently doing in your community to promote mental health awareness?</p>		

**Members must make every effort to attend all meetings in person or with accommodation. Mileage reimbursement will be provided by Indiana Disability Rights when attending the meetings. The Mental Illness Advisory Council meets four times a year, with meetings held on Monday afternoons. (Date and location of meetings are subject to change.) Additional time commitments may include project/committee work, related meetings, public education initiatives, etc.**

Signature

Date completed (*month, day, year*)