PLANNING AND NETWORK ADVISORY COMMITTEE
Membership Application Form

If you would like to participate in the Border Region Behavioral Health Center Planning and Network Advisory Committee, please complete the requested information below. We will use this information to contact you in the future a well as to determine if we have the required membership constituency.

Name ________________________________ Address ________________________________

City ________________________ State ________________________ Zip Code _______________

Phone (Home) ___________________ (Work) ___________________ (Cell) __________________

E-mail address _____________________________ Occupation _______________________________

Please check the one that describes you the best :

_____ Person receiving Mental Health (MH) services
_____ Person receiving Intellctual and Developmental Disabilities services (IDD)
    _____ from Border Region BHC
    _____ from Other

_____ Not receiving services now but received services in the past
    (please specify) ____MH services or _____IDD services and how long ago ________________
    _____ from Border Region BHC
    _____ from Other

_____ Family member of person receiving MH services (please specify relationship) ________________
_____ Family member of person receiving IDD services (please specify relationship) ________________
    _____ my relative receiving services is 18 years or older
    _____ my relative receiving services is under 18 years old

_____ Primary caregiver or legal representative
    _____ of person 18 years or older
    _____ of person under 18 years old

_____ Family member received services in the past
    (please specify) ___ MH services or ____ IDD services, relationship __________________and how long ago ______________; if family member who received services is currently under 18 years old, -please state how many years ago services were received ____________________

_____ Community member

_____ Public official

_____ Provider of mental health services (please specify) ____

_____ Other health provider (please specify) ____

_____ Other interested party

Please describe why you would like to serve on this committee ___________________________________

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