

AREA AGENCY ON AGING, PSA 2
ADVISORY COUNCIL
APPLICATION FORM

Representative for Champaign County

Thank you for your interest in our program. Please print or type the following information. Feel free to attach continuation pages and/or letters of support.

| | |
|--|--|
| Name: | <input type="checkbox"/> I am a resident of Champaign County. <input type="checkbox"/> I am not a resident, but I work in Champaign County. |
| Address: | Home phone: Work phone: E-mail: |
| Occupation: | Employer: |
| | Birthdate: / / |
| If applicable, how long have you been a resident of this county? | |
| Race: Caucasian <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> | |
| Do you have a disability? yes <input type="checkbox"/> no <input type="checkbox"/> | |
| Do you use or have experience with services funded by the Area Agency on Aging (such as congregate meals, Healthy U workshops, etc.)? | |
| yes <input type="checkbox"/> no <input type="checkbox"/> uncertain <input type="checkbox"/> | |
| Are you employed by, or hold financial interest in, an agency receiving funds from the Area Agency on Aging? | |
| yes <input type="checkbox"/> no <input type="checkbox"/> uncertain <input type="checkbox"/> | |
| Please check any of the following that apply to you: | |
| <input type="checkbox"/> Representative of a health care provider organization <input type="checkbox"/> Local elected official <input type="checkbox"/> Representative of a faith-based organization | |
| Please describe your experience working with older adults, elderly services programs, senior citizen centers, etc. (especially emphasize any leadership experience): | |
| | |

Relevant organizations to which you belong:

Special Interests:

I have reviewed the enclosed position description for Area Agency on Aging Advisory Council members. I understand that appointment to the position involves participation in the responsibilities of being a representative of my county to this council.

I agree to notify the Area Agency if a conflict of interest arises. I understand that I will be asked to resign should such a conflict occur, or if it is determined that I am not fulfilling the duties of the office.

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application as may be necessary in arriving at a decision.

Signature of applicant and date:

DEADLINE FOR SUBMISSION IS FEBRUARY 28, 2020.

MAIL TO: AREA AGENCY ON AGING, PSA 2
ATTN: KARIN NEVIUS
40 WEST SECOND ST., SUITE 400
DAYTON, OH 45402

For Office Use Only:

Was applicant appointed? yes no

Type of appointment: new replacement

Effective date of appointment: