

**AREA AGENCY ON AGING, PSA 2  
ADVISORY COUNCIL  
APPLICATION FORM**

**Representative for \_\_\_\_\_ 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 _____ county. <input type="checkbox"/> I am not a resident, but I work in _____ 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     Black     American Indian     Hispanic   
                                  Asian/Pacific Islander

Do you have a disability?    yes     no

Do you use or have experience with services funded by the Area Agency on Aging (such as congregational meals, Healthy U workshops, etc.)?

yes     no     uncertain

Are you employed by, or hold financial interest in, an organization receiving funds from the Area Agency on Aging?

yes     no     uncertain

Please check any of the following that apply to you:

- Representative of a health care provider organization
- Local elected official
- 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 you belong to:

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 26, 2021.**

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: