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: | ☐ I am a resident of _____ county.<br>☐ I am not a resident, but I work in _____ county. |
| Address: | Home phone:<br>Work phone:<br>E-mail: |
| Occupation: | Employer:<br>Birth year: |

If applicable, how long have you been a resident of this county?

Race: White/Caucasian ☐ African American/Black ☐
American Indian/Alaska Native ☐ Hispanic/Latino ☐ Asian/Asian American ☐
Native Hawaiian/other Pacific Islander ☐ prefer not to answer ☐ other ☐

Do you have a disability? yes ☐ no ☐ prefer not to answer ☐

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

yes ☐ no ☐ uncertain ☐

Are you employed by, or hold financial interest in, an agency 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):

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|---|
| 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.<br><br>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.<br><br>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: |

MAIL TO: AREA AGENCY ON AGING, PSA 2

ATTN: Kelsey Snowden
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: |