

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:
	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):

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:

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: