

**RECIPIENT RIGHTS ADVISORY COMMITTEE  
RECIPIENT RIGHTS APPEALS COMMITTEE  
MEMBERSHIP APPLICATION**

If you require assistance in completing this application, please contact the NLCMH Executive Office at 231-935-3677 or Toll Free at 1-800-337-8598.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMPLOYER PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Which number is best to reach you?

**Home**     **Business**     **Cell**  
 **Email**

**Please return your completed application to:**

**NORTHERN LAKES COMMUNITY MENTAL HEALTH  
EXECUTIVE OFFICE  
105 HALL STREET  
TRAVERSE CITY, MI 49684**

The Northern Lakes CMH Board will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs. Auxiliary aid and services are available upon request to individuals with disabilities.

- 1. Which of the following categories best describes you (refer to definitions above):**

Primary Consumer     Family Member     Community Member-at-Large

- 2. Briefly explain how your experience fits one or more of these categories?**

- 3. Which of the following populations, if any, would you best be able to represent?**

Adults with Serious Mental Illness  
 Adults with Developmental Disability  
 Children with Developmental Disability  
 Children with Severe Emotional Disturbance

**Explain:**

- 4. Briefly explain why you are interested in becoming a member of the Recipient Rights Advisory Committee and the Recipient Rights Appeals Committee:**

- 5. Please list any special experiences, resources, and/or knowledge you will bring to the committees:**

**6. What do you think are the most critical challenges and/or issues facing persons with disabilities today?**

**7. Do you have any conflicts of interest that would prevent you from serving on the committees?**

NO  YES (explain)

**8. Will you be able to attend all scheduled meetings?**

YES  NO (explain)

**9. Do you need any special accommodations to assist you in serving on the committees?**

NO  YES (explain)

I understand that this application will be shared with the NLCMH Board of Directors to review information necessary for the appointment of the Recipient Rights Advisory Committee and the Recipient Rights Appeals Committee members. I further agree, if appointed, to permit my name to be added to the committee membership list. I understand that this list is available to any individual upon request but that it will not include any confidential information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_