



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
DIVISION OF BEHAVIORAL HEALTH - STATE ADVISORY COUNCIL FOR COMPREHENSIVE PSYCHIATRIC SERVICES
MEMBERSHIP APPLICATION

NAME			
MAILING ADDRESS		E-MAIL ADDRESS	
CITY		STATE	ZIP CODE
COUNTY	FAX#	HOME TELEPHONE	BUSINESS TELEPHONE
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		RACE	
<input type="checkbox"/> FAMILY MEMBER <input type="checkbox"/> INDIVIDUAL WITH LIVED EXPERIENCE			
1. WRITE A BRIEF STATEMENT EXPLAINING WHY YOU WOULD LIKE TO SERVE ON THE CPS STATE ADVISORY COUNCIL. (MAY USE ADDITIONAL SHEET IF NECESSARY.)			
2. IT IS IMPORTANT THAT THE INFORMATION RECEIVED DURING THE CPS SAC MEETINGS BE DISSEMINATED TO THE REGION YOU REPRESENT. HOW WILL YOU BE ABLE TO SHARE THE INFORMATION?			
ARE YOU CURRENTLY A BOARD MEMBER, THE SPOUSE OF A BOARD MEMBER, OR AN EMPLOYEE OF ANY AGENCY HAVING A CONTRACT WITH THE MISSOURI DEPARTMENT OF MENTAL HEALTH IN EXCESS OF FIFTEEN HUNDRED DOLLARE (\$1,500)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING			
NAME OF AGENCY			
STREET ADDRESS			
CITY		COUNTY	STATE
			ZIP CODE
SIGNATURE			DATE
THIS SECTION TO BE COMPLETED BY DIVISION OF BEHAVIORAL HEALTH STAFF			
REGION		DATE TERM WILL END	
Please submit completed application to Lexy Thompson at alexa.thompson@dmh.mo.gov or fax to 573-751-7815.			