**Parent Advisory Council (PAC) Membership Application**

Please check the box next to the PAC you are applying to be a member of:

Central Missouri PAC  Southeast Missouri PAC  East Missouri PAC

Northwest Missouri PAC  Southwest Missouri PAC

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| --- | --- | --- | --- | --- | --- |
| Name:  Click to enter text. | | MO Resident Yes/No:  Click | | Regional Office:  Click | |
| Home Address:  Click to enter text. | | City  Click | | State  MO | Zip Code  Click |
| Occupation:  Click or tap here to enter text. | County:  Click to enter text | | Home Phone:  Click to enter text. | | |
| Email Address:  Click or tap here to enter text. | | | Cell/Work Phone:  Click to enter text. | | |

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| --- | --- | --- | --- | --- |
| **How did you become aware of the Parent Advisory Council?** | | | | |
| Click or tap here to enter text. | | | | |
| **Why are you interested in becoming a member of the Parent Advisory Council in your region?** | | | | |
| Click or tap here to enter text. | | | | |
| **Please list all affiliations, organizations (e.g. volunteer, associations, civic groups, etc…) Please indicate the nature of your involvement.** | | | | |
| Click or tap here to enter text. | | | | |
| **Are you a service provider, member of a service provider board, provider’s board of directors, or an employee of a service provider or DMH Division of Developmental Disabilities\*? Yes  No** | | | | |
| **Age & Name of family member with autism**  Click or tap here to enter text. | | **Relationship to family member with autism**  Click or tap here to enter text. | | |
| **Family member with autism meets Division of Developmental Disabilities eligibility requirements**  **Yes  No** | | | | |
| **Applicant Signature:** | Click or tap here to enter text. | | **Date:** | Click |
| **Application Submitted to:** | Click or tap here to enter text. | | **Date:** | Click |