**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. | CityClick  | StateMO | Zip CodeClick  |
| 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 |