



**Oregon Home Care Commission  
Developmental Disabilities and Mental Health Committee  
Interest Form**

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The purpose of this form is to assist the Oregon Home Care Commission in selecting members for the Developmental Disabilities and Mental Health Committee. **Please complete the entire form and return by mail, e-mail, or fax:**

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Mail      **Oregon Home Care Commission  
676 Church Street NE  
Salem, OR 97301**

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E-mail    **DD-MH.OHCC@state.or.us**

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Fax        **503-378-5886**

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If you have questions, please call 503-378-2733

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**Category you represent:**

**Developmental Disability:**

Consumer      Family member      Advocate      Personal support worker  
Brokerage      Agency  
Other

**Mental Health:**

Consumer      Family member      Advocate      Personal support worker  
Agency  
Other

If you are a consumer, have you received any self-advocacy training?      Yes      No

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**FOR OFFICE USE ONLY**

Date Received:      Appointed:      Yes      No      Date:

Oregon Home Care Commission Chair Approval  
Executive Director Approval

## Personal data

### Preferred mailing address:

First name

**Home**

Middle initial

**Business**

Last name

Home mailing address

City

ZIP code

County

Business name

Business address

City

ZIP code

County

### Preferred phone number:

Home phone number

**Home**

**Business**

Business phone number

Cell phone number

Business fax number

### Preferred e-mail address:

Home e-mail address

**Home**

**Business**

Business e-mail address

## Education

Schools attended, include high school. A current resume may be substituted for this section.

School

City

State Dates

Degree/Major

## Employment and experience

List major paid employment and significant volunteer activities. A current resume may be substituted for this section.

Dates (from-to)

Employer/Organization

City

State

Title/Position

Why do you want to join the Developmental Disabilities and Mental Health Committee?  
Describe in detail why you are interested in serving on the Developmental Disabilities and Mental Health Committee.

## Acceptance

**I will accept appointment if selected by the Oregon Home Care Commission, and if appointed, I pledge my best efforts to resolve, before assumption of the position, any conflicts of interest that would be inconsistent with my responsibilities as an appointee to the Oregon Home Care Commission Developmental Disabilities and Mental Health Committee. Appointment to this committee does not constitute Commission membership. Appointees are not eligible for compensation related to attending.**

Signature

Date

***Your electronically submitted application will be considered a “signature signed” application by the Oregon Home Care Commission.***

For more information or additional interest forms, please visit the Oregon Home Care Commission website: [www.oregon.gov/DHS/spd/adv/hcc/committees.shtml](http://www.oregon.gov/DHS/spd/adv/hcc/committees.shtml)

### Optional information

To assist us in meeting our affirmative action objectives, we would appreciate information about your gender and background. This information is optional. Under state and federal law, this information may not be used to discriminate against you.

<b>Gender</b>	<b>Race/Ethnicity</b>	<b>Disability</b>
Male	Asian or Pacific Islander	Native American
Female	Black	White
	Hispanic	Multiracial/Other

This document can be provided upon request in alternative formats for individuals with disabilities. Other formats may include (but are not limited to) large print, Braille, audio recordings, Web-based communications and other electronic formats. E-mail [DD-MH.OHCC@state.or.us](mailto:DD-MH.OHCC@state.or.us) or call 503-378-2733 to arrange for the alternative format that will work best for you.