

**Application Form** (rev 10/15/2014)  
**Disability Rights Wisconsin PAIMI Advisory Council**  
**Protection and Advocacy for Persons with Mental Illness**

If you have questions, or wish to request an alternative format, please contact Barbara Beckert at Barbara.beckert@drwi.org. Disability Rights Wisconsin or call 414-773-4646.

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

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

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

PHONE: (\_\_\_\_) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

SEX:                    \_\_\_ MALE \_\_\_ FEMALE

AGE RANGE:        \_\_\_ 18 – 39                    \_\_\_ 40 – 59                    \_\_\_ 60 and over

I am a Wisconsin resident and live in \_\_\_\_\_ County. (mandatory)

**Please check all categories below that apply to you:**

I am a person who has received or is receiving mental health services.

I am a family member of a person who has received or is receiving mental health services.

If a family member, please state your relationship: \_\_\_\_\_

Note: If you are a parent of a minor child or youth receiving mental health services, note the child's age: \_\_\_\_\_

I am an attorney.

I am a mental health professional \_\_\_\_\_

I am a provider of mental health services \_\_\_\_\_

I am a person from the public who is knowledgeable about mental illness, the advocacy needs of people with mental illness and have demonstrated a substantial commitment to improving mental health services.

**My race/ethnicity is:**

Asian

Black, not of Hispanic/Latino origin

Hispanic/Latino

Pacific Islander

North American Indian or Alaskan Native

White, not of Hispanic/Latino origin

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Please answer the following:

1. Why do you want to participate on the PAIMI Advisory Council?
  
2. Describe your advocacy experience (advocating for oneself, a family member or others).
  
3. Priorities for the PAIMI program include advancing the rights of people with mental illness and supporting empowerment and recovery. What are your views about the rights of people with mental illness, empowerment, and recovery?
  
4. Describe your involvement on committees, organizations, conferences/trainings, etc. that address mental health issues. Please include the names of committees, organizations, etc.

5. Describe your educational/work experience or other lived experience that may be relevant to the work of the PAIMI Advisory Council.
  
  
  
  
  
  
  
  
  
  
6. Provide the name and phone number and or email address of two references who are knowledgeable about your advocacy efforts/involvement regarding mental health issues.
  
  
  
  
  
  
  
  
  
  
7. Do you bring other lived experience that would enhance the PAIMI Advisory Council such as service as a veteran, racial, ethnic or cultural diversity, gender or sexual orientation, etc?

**PLEASE READ AND SIGN:**

The PAIMI Advisory Council may request an interview which can be conducted either by phone or in person. If selected to serve on the PAIMI Advisory Council, I agree to participate in the PAIMI Advisory Council meetings and my participation may be by teleconference calls. I understand that if I am unable to attend official PAIMI Advisory Council meetings on a regular basis, that I may be removed. I also understand that I will be reimbursed for my travel costs in order to participate in the PAIMI Advisory Council activities.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

You may submit this application by mail, fax, or email:

PAIMI AC Applications  
Disability Rights Wisconsin  
Attn: Barbara Beckert  
6737 W. Washington St., Suite 3230  
Milwaukee, WI 53214

Fax: 414-773-4647, attention Barbara Beckert Email: [Barbara.beckert@drwi.org](mailto:Barbara.beckert@drwi.org)