Developmental Disabilites/
Mental Health Committee

DEVELOPEMANTAL DISABILITIES & MENTAL HEALTH COMMITTEE APPLICATION

Developmental Disabilities and Mental Health Committee Application Form

In 2010, House Bill 3618 amended ORS 410.600, requiring the Oregon Home Care Commission to create a Developmental Disabilities and Mental Health Committee to Fulfill the Oregon Home Care Commission duties and functions including:

- Qualifications for personal support workers.
- Maintain a statewide registry of personal support worker
- Provide training opportunities for personal support worker and consumers
- To serve as the "employer of record" for purposes of collective bargaining for personal support worker who are paid from public funds.

The Committee Responsibilities

The committee provides information and makes recommendations to the commission on:

- Improving the quality of services available to person with developmental disabilities or mental illnesses and the family members of persons with developmental disabilities or mental illnesses.
- Ensuring that an adequate amount of services are available to persons with developmental disabilities or mental illnesses and family members of person with developmental disabilities or mental illnesses.

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 conflict of interest that would be inconsistent with my responsibilities as appointee to the Oregon Home Care Commission Developmental Disabilities and Mental Health Committee. Appointees are not eligible for compensation related to attending.

Signature _____
Date_____

Oregon Home Care Commission
550 Capital street NE, Basement Level
Salem OR 97301
DD-MH.OHCC@Sate.or.us
Fax 503-378-5886 / **Phone** 503-378-3121

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Oregon Home Care Commission 550 Capital Street NE Salem, OR 97301 / DD-MH.OHCC@Sate.or.us
Fax 503-378-5886 / **Phone** 503-378-3121

The purpose of this form is to assist the Oregon Homes Care Commission in selecting members for the Developmental Disability and Mental Health Committee. Please complete the entire form and return by mail, email, or fax above.
Please type or print clearly.

SECTION 1: Applicant Contact Information

First Name	Last Name	
Mailing Address		
City	State	Zip Code
Date of Birth *(optional)*	Place of Birth *(optional)*	
Phone Numbers ( ) — ( ) ---	E-mail	

Category you represent

Development Disability	Mental Health
☐ Consumer	☐ Consumer
☐ Brokerage	☐ Brokerage
☐ Family Member	☐ Family Member
☐ Advocate	☐ Advocate
☐ Personal Support Worker	☐ Personal Support Worker
☐ Agency _____	☐ Agency _____
☐ Other _____	☐ Other _____

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SECTION 2: Demographic Information

*This information is **optional**. Under federal and state law, this information cannot be used to discriminate against you. We will use this information to support equitable representation on the committee.*

A. Race *(check all that apply)*

☐ American Indian or Alaska Native

Asian:
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Other Asian: _____

☐ Black or African American

Pacific Islander:
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander

☐ White

☐ Decline to Answer
☐ Unknown
☐ Other:

_____

B. Primary Race Identity *(check one)*

☐ American Indian or Alaska Native

Asian:
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Other Asian: _____

☐ Black or African American

Pacific Islander:
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander

☐ White

☐ Decline to Answer
☐ Unknown
☐ Other:

_____

☐ No Primary Race Identity

C. Ethnicity *(check all that apply)*

☐ **Not** of Hispanic, Latino/a, or Spanish origin

Hispanic, Latino/a, or Spanish origin:
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Other Hispanic, Latino/a, or Spanish origin: _____

☐ Decline to Answer
☐ Unknown

D. Gender Identity

☐ Man
☐ Woman
☐ Other: _____
☐ Decline to Answer

E. Sexual Orientation

☐ Heterosexual
☐ Bisexual
☐ Gay
☐ Lesbian
☐ Other: _____
☐ Decline to Answer

OREGON Home Care COMMISSION
Developmental Disabilites/
Mental Health Committee

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Experience Please provide major paid employment and significant volunteer activities and educational background or attach your resume.

Name of school, employment or volunteer agencies	Dates of Activities	City and state	Scope or focus of your participation (Title and position)

References Please list two or three people who can provide information about your potential contributions to the DD/MH Committee.

Name	Title/Affiliation	Phone	Email

SECTION 5: Signature

I certify that the statements made by me on this form are true and correct to the best of my knowledge and belief.

Signature of Applicant **Date**

Note: Completion of this application does not confirm membership on the Committee.

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SECTION 4: Interest and Experience

Please describe why you are interested in serving on the Developmental Disabilities and Mental Health Committee?

Please describe how your background and experience would support your work on this Committee.