GRATIOT INTEGRATED HEALTH NETWORK

Consumer & Family Advisory Committee Application

Name: _____ _____

Street Address: _____

City, State, Zip Code: _____

Phone: _____ _____

Email: _____

May we send meeting reminders and meeting packets to your email? ◯ Yes ◉ No

Primary Language: _____

Additional languages spoken: _____

Do you need any accommodations? ◯ Yes ◯ No

If yes, what accommodation do you need: _____

Do you have access to the Internet & technology? ◯ Yes ◯ No

Are you familiar with Microsoft Teams? ◯ Yes ◯ No

Do you have transportation to get to GIHN? ◯ Yes ◯ No

GIHN is seeking people who have lived experience & are willing to serve on this committee:

I am: Please check all that applies to you. ☐ Consumer ☐ Family Member ☐ Caregiver

I belong or am connected to, the following: Please check all that apply.

☐ Child with Severe Emotional Disturbance

☐ Child with Autism Spectrum Disorder

☐ Adult with Mental Illness

☐ Person with Substance Use Disorder

☐ Person with Developmental or Intellectual Disability

GIHN programs that you have knowledge of/experience with. Please check all that apply.

☐ Access	☐ Crisis	☐ Autism
☐ Case Management	☐ Intensive Family Based Services	☐Occupational Therapy
☐ IPS Employment Services	☐ Supported Employment Services	☐ Peer Support
☐ Skill Building	☐ MAT Clinic	☐ Infant Mental Health
☐ Heath Services	☐ Psychiatric Services	☐ Outpatient Therapy
☐ Dietary	☐ CLS	☐ PERS

Please share your interests and skills:_____

_____

_____

Time Commitment

The GIHN Consumer & Family Advisory Committee meets every other month for an hour. The Committee reserves the right to appoint members to smaller sub-committees for select assigned tasks. We request that you attend all primary meetings. Please note, that while we prefer you to attend in person, we will have an electronic option, MS Teams, available.

Are you able to attend all the meetings? ◉ Yes ○ No

Food Concerns: Food is normally provided at the meetings.

Do you have any food allergies? ◉ Yes ○ No

If yes what are the allergies: _____

Do you have any food sensitivities? ○ Yes ◉ No

If yes what are the sensitivities: _____

Are there any food-related cultural, or dietary concerns that we need to be aware of/sensitive to:

_____

_____

By signing this application, you agree to participate in the GIHN Consumer & Family Advisory Committee for your term of service if selected by the Board of Directors and Chief Executive Officer.

_____ _____

Applicant Signature **Date**