Application Form (rev 03/2025)

Disability Rights Wisconsin PAIMI Advisory Council

Protection and Advocacy for Persons with Mental Illnesses

If you have questions or wish to request an alternative format,
please contact Ellie Jarvie via email at elliej@drwi.org
or Disability Rights Wisconsin by calling 1-800-928-8778

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **E-Mail:** _____

Gender (optional)**:** ☐ Male ☐ Female ☐ Non-Binary ☐ Prefers not to say
☐ Another gender not listed: _____

Pronouns (optional)**:** _____

Age Range (required)**:** ☐ 18-39 ☐ 40-59 ☐ 60 and over

I am a Wisconsin resident and live in _____ County. (required)

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. Type of professional: _____

☐ I am a provider of mental health services. Type of provider: _____

☐ 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 ethnicity is (optional; can select multiple choices)**:**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Another ethnicity not listed: _____

My race is (optional; can select multiple choices)**:**

- ☐ Asian
- ☐ Black or African American
- ☐ Hawaiian / Other Pacific Islander
- ☐ Indigenous, First Nation, or Alaskan Native
- ☐ White
- ☐ Another race not listed: _____

Please answer the following questions.
If filling this form out digitally, answer fields will expand to accommodate longer answers. If filling this form out on paper, you may include extra paper along with this application if you require more space.

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. **Email is preferred**.

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Attn: Ellie Jarvie
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Suite 201
Madison, WI 53713

Fax: 1-833-635-1968, Attn: Ellie Jarvie

Email: elliej@drwi.org