



APPLICATION FOR THE CENTER FOR HEALTH CARE SERVICES' PLANNING AND NETWORK ADVISORY COMMITTEE ("PNAC")

6800 Park Ten Blvd. Suite 200-S, San Antonio, Texas 78213
Phone: (210) 261-1000 Fax: (210) 785-9143

TITLE (OPTIONAL): MR. MRS. MS. DR. REV. Today's Date: _____

LAST NAME _____ FIRST NAME _____ MI _____

HOME ADDRESS: _____ ZIP CODE _____

DATE OF BIRTH: ____/____/____ GENDER (OPTIONAL): MALE FEMALE

PHONE: _____ EMAIL: _____

Please choose one of the following categories to describe yourself (as required by contract with TX Department of State Health Services):

MH consumer IDD consumer Family member, not consume Advocate, not family/consumer

How do you identify ethnically/racially (optional)?

Latin/Hispanic Anglo Black Asian Pacific Islander Native American Alaskan Native

Meetings will be conducted in English, but do you speak other languages (optional)?

Spanish American Sign Other (please specify) _____

Briefly describe why you want to serve on the PNAC and how the Center, its consumers, family members, and stakeholders would benefit from your appointment (e.g. experience with mental health treatment and issues, treatment and issues concerning intellectual and developmental disorders, substance abuse treatment and issues, healthcare planning or public health policy, financial planning, contracts and procurement, serving on strategic/advisory councils or boards, etc.).

I understand that PNAC membership will require a commitment on my part to complete required member training, attend committee meetings, complete committee work assignments on time, and bring the best of my capabilities to studying and understanding the issues presented before the Committee. PNAC members will provide advice that will have significant implications for the current and future business of The Center for Health Care Services and the services it provides to the citizens of Bexar County. This is a responsibility I promise to uphold.

Signature: _____ **Date:** _____