PERSONAL ASSISTANCE SERVICES PROGRAM (PASP)
State Consumer Advisory Council on Personal Assistance Services

MEMBERSHIP APPLICATION

Today's Date: _____/_____/_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Email Address: _____

Phone # Home: _____ Work: _____ Cell: _____

CHECK ALL ACTIVITIES THAT APPLY TO YOU:

_____ Employed Full or Part Time **_____Searching for Employment**

_____Participate as a Volunteer Professional **_____Organization Representative**

_____Attending Educational Program **_____ Other_____**

CHECK 'YES' OR 'NO' TO THE FOLLOWING QUESTIONS:

Are you a PASP consumer? Yes _____ No _____

If not, where do you receive your services from? _____

Will you be able to attend (4) regularly scheduled meetings during the year (March, May, September and November)? Yes _____ No _____

Will you be able to provide your own transportation? Yes _____ No _____

Have you previously participated in teleconferences? Yes _____ No _____

PLEASE USE ADDITIONAL PAGES IF NEED BE TO ANSWER THE FOLLOWING QUESTIONS:

Why are you interested in becoming an Advisory Council Member for PASP?

_____

_____

What qualities do you possess that will be useful as a member of the NJ State Consumer Advisory Council on Personal Assistance Services?

_____

Describe your experience in serving on committees, boards or in other advisory capacities?

What did those committees, boards or advisory councils accomplish during your involvement?

What experience do you have in working with legislators at the county, state or federal level?

Would you be interested in doing public speaking? **Yes _____ No _____**

Would you be interested in being trained to serve on the PASP Speaker's Bureau to provide information to the public? **Yes _____ No _____**

Any additional information you would like to share in consideration of your application:

PLEASE ALSO INCLUDE A RECENT RESUME AND AT LEAST (2) LETTERS OF RECOMMENDATION WITH YOUR APPLICATION. NO APPLICATION WILL BE CONSIDERED WITHOUT THIS ADDITIONAL SUPPORTING DOCUMENTATION. THANK YOU.

PLEASE SUBMIT YOUR COMPLETED APPLICATION TO:

NJ State Personal Assistance Services Program
C/O Consumer Advisory Council
Division of Disability Services
PO Box 705
11A Quakerbridge Road
Trenton, New Jersey 08625-0705
Email Address: Dianna.Maurone@dhs.state.nj.us