

BENT/CROWLEY/OTERO COUNTY CASE MANAGEMENT AGENCY COMMUNITY ADVISORY COUNCIL
DECLARATION OF INTEREST
(PLEASE PRINT)

NAME _____

COUNTY OF RESIDENCE (PLEASE CIRCLE) BENT CROWLEY OTERO

PREFERRED CONTACT INFORMATION (PHONE/EMAIL) _____

AFFILIATION
(MARK ALL THAT
APPLY)

_____ MEMBER WITH INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITY

_____ MEMBER WITH OTHER DISABILITY

_____ FAMILY MEMBER

_____ PROFESSIONAL (PLEASE CHOOSE ONE OR MORE OF THE FOLLOWING)

_____ COUNTY COMMISSIONER

_____ AREA AGENCY ON AGING

_____ MEDICAL PROFESSIONAL

_____ PHYSICAL OR INTELLECTUAL DISABILITY PROFESSIONAL

_____ OMBUDSMAN

_____ HUMAN SERVICE AGENCY

_____ COUNTY GOVERNMENT OFFICIALS

_____ MENTAL/BEHAVIORAL HEALTH PROFESSIONALS

_____ HCBS PROFESSIONALS WITH EXPERIENCE WORKING WITH MEMBERS
WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES