

**Nominee's Application for Membership on the
East Central Illinois Area Agency on Aging
ADVISORY COUNCIL**

Introduction: The Older Americans Act (OAA) requires the Area Agency on Aging to establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care, and the general public, to advise the Area Agency on Aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan. ECIAAA requests that nominees applying for membership on the Advisory Council disclose information necessary to comply with OAA requirements. ECIAAA will maintain the confidentiality of information disclosed in this application.

NOMINEE INFORMATION: Please circle or check the appropriate choices below.

Name: (Mr./Mrs/Ms.) _____

Street Address: [Click here to enter text.](#) _____ Apt. Number _____

City [Click here to enter text.](#) _____, Illinois **Zip Code:** _____

E-mail Address [Click here to enter text](#) _____

Home Phone: [Click here to enter text](#) _____

Work Phone: [Click here to enter text.](#)

Mobile Phone:

Age **Birthdate** (optional):_ **Male**_ **Female**_

Number of person(s) living in your household:

Caregiver - an "informal" provider of in-home and community care to an adult 60 or older_

Grandparent or other relative 60 or older who is primary caregiver of a child in your household _

Race

Native Hawaiian or Other Pacific Islander

White

Asian Black or African American

Ethnicity

Hispanic or Latino

Not Hispanic or Latino

Income at or below the Federal Poverty Level - Is your annual income at or below the following levels?

Family Size	2018 Federal Poverty Level*	Check if applicable
1	\$12,490	
2	\$16,910	
3	\$21,330	
4	\$25,750	

I. Nominee Affiliations:

Do you serve as public official? _____ If yes, please describe your duties:

Have you used or participated in any in-home or community-based programs and services available to older adults in your community or county? ___ Yes _____ No _____ If yes, please describe:

Please specify other service organizations or memberships in which you are or have been involved:

II. Interest in Serving Seniors:

In the space below, please note any current involvement you have in working with older persons (e.g. volunteer in a service program, participation on a committee that is concerned with the needs of older adults or helping them receive needed services, etc.)

Please indicate why you are interested in serving as a member of the Area Agency Advisory Council:

III. Term of Membership: _____ **Representing:** _____ County

The term of membership checked below is currently available:

Full 3-year term ending September 30, _____

Balance of a vacant term ending September 30, _____

IV. Statement of Interest:

I would be willing to serve on the Advisory Council for the East Central Illinois Area Agency on Aging for the term of membership noted above. I understand that I will be expected to attend all scheduled meetings and serve the Area Agency on Aging as necessary and appropriate to this membership.

Nominee's Signature: _____ Date: _____

Recommended by: _____ Phone Number of Nominator: _____

*According to [US Department of Health & Human Services](#)