Region 5 Behavioral Health Board

Application of Intent to Serve

Name: Home Ph:
Mailing Address (incl city, state, zip) Work Ph:
Email: Cell Ph:

Daily Activity/Occupation:

Did a community organization, board, commission, committee or council nominate you?

NO ☐ If YES, please list:

Please tell us about your special interests, skills, and/or experiences related to the fields of mental health, behavioral health and/or substance use disorder. Include any experience with boards, councils, committees, etc.

Please add any other information you think is relevant to your appointment.

Are you willing and able to attend monthly meetings? YES ☐ NO ☐
(SCBHB usually meets on the 2nd Wednesday of every other month, 11:30 a.m. - 1:00 p.m. in Twin Falls)

Are you willing to volunteer for committees and/or special projects? YES ☐ NO ☐

MY APPLICATION BEST FILLS THE FOLLOWING STATE-REQUIRED REPRESENTATIVES (select up to 3):

- ☐ County Commissioner or their designee
- ☐ Department of Health and Welfare employee
- ☐ Parent of a child with a serious emotional disturbance
- ☐ Parent of a child with a substance use disorder
- ☐ Law enforcement officer
- ☐ Adult mental health consumer representative
- ☐ Mental health advocate
- ☐ Substance use disorder advocate
- ☐ Adult substance use disorder consumer rep
- ☐ Family member of an adult mental health consumer
- ☐ Family member of an adult SUD consumer
- ☐ Private provider of mental health services
- ☐ Private provider of substance use disorder services
- ☐ School district rep (elementary or secondary)
- ☐ Juvenile justice system representative
- ☐ Adult correction system representative
- ☐ Judiciary representative
- ☐ Physician or other licensed health practitioner
- ☐ Hospital representative
- ☐ Prevention Specialist

APPLICANT SIGNATURE DATE

Please Return This Application To:

South Central Public Health District
Attn: SCBHB
1020 Washington St. N., Twin Falls, ID 83301-3156
FAX: (208) 734-9502