State Consumer and Family Advisory Committee  
Nomination Form  

Note: All completed forms should be sent to:  
Suzanne B. Thompson, Team Leader  
Community Engagement and Empowerment  
3001 Mail Service Center  
Raleigh, NC 27699-3001  
suzanne.thompson@dhhs.nc.gov  
(919) 268-7386 – State Cell  

Customer Service and Community Engagement & Empowerment Teams  
(919) 715-3197 – Phone  (919) 733-4962 – Fax  

NOMINEE INFORMATION:  

Name:______________________________________  
Self nomination____ or Nominated by _____________________________________________  
Has nominee consented to serve if selected? ____Yes____No  

Address:__________________________________________________________________  
City:_____________________________ Zip:______________ County:____________________  
Phone:___________________________ E-Mail:____________________________________  

Gender:  Male_____ Female_____  

Ethnic Background: African-American_____ Hispanic___ Native American _____Asian______  
Caucasian______ Other (Please Indicate)__________________________________________  

Nominee is a: _____ Consumer _____Family Member of Consumer (i.e.: parent, spouse, etc.)  

Nominee represents which of the following disability groups:  
____mental health   ____developmental disabilities   ____substance abuse  

Relationship to Consumer (if a Family Member)_____________________________________  

PLEASE LIST ALL OF THE NOMINEE’S INVOLVEMENTS IN MH/DD/SA IN THE  
COMMUNITY (Check everything that applies)  

_____ Member of local Consumer and Family Advisory Committee (name) ________________  

_____ Local advocacy group(s) (list) _______________________________________________  

Do you work directly or contract with any of the following:  
_____ local LME/AP ______ provider agency _____ advocacy group _____ other  
(give details of work)_____________________________________________________________  

Other involvement with your local LME or Providers (explain)_________________________  

______________________________________________________________________________  

Applicants with disabilities and needs requiring special accommodations may  
contact our office. Appropriate arrangements can be made to ensure successful  
participation on the State CFAC.
NOMINEE’S INTEREST AND QUALIFICATIONS

Please check all areas that apply to applicant:
___ Ability to Influence Policy
___ Served on other Boards/Committees
___ Telephone Skills
   (Research/Collection of Information)
___ Statistics/Survey Development/
   Evaluation of Surveys
___ Email Use
___ Writing/Summarizing Reports
___ Editing Documents
___ Calculating
___ Disability Specific Knowledge

Computer abilities:
___ MS Word Processing
___ Access Database
___ Publisher
___ Excel Spreadsheets
___ PowerPoint
___ Internet Research

Please describe the nominee’s qualifications to serve on the State Consumer and Family Advisory Committee. Make sure that you include all relevant experience that relates to advocacy, productive team building, and problem-solving skills:

Please include a brief bios.