# ALZHEIMER’S DISEASE AND RELATED CONDITIONS ADVISORY COMMITTEE (ADRCAC) APPLICATION

***REASONABLE ACCOMMODATIONS:***If you require a disability-related accommodation, materials in alternate format or auxiliary aids/services, or translation services to complete this application, please email Engage@aging.ca.gov or call (916) 419-7500.

**\*** = answer required

1. \***Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \***Do you currently reside in the state of California?** \_\_\_ Yes \_\_\_ No
3. **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **\*Phone number**: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **\*E-mail address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **\*What best describes your gender identity?**

\_\_\_ Female/ Cis-gender female (gender matches sex assigned at birth)

\_\_\_ Male/ Cis-gender male (gender matches sex assigned at birth)

\_\_\_ Transgender (gender differs from sex assigned at birth)

\_\_\_ Genderqueer non-conforming (behavior or appearance does not align with cultural gender expectations)

\_\_\_ Don't know

\_\_\_ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Prefer not to answer

1. **\*Identify which geographic area(s) you live, or if you represent an organization or association, you primarily serve:** (Select all that apply)

**\_\_\_ North Rural** (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yuba)

**\_\_\_ North Central** (Alpine, Amador, Calaveras, El Dorado, Napa, Placer, Sacramento, Solano, Sonoma, Yolo)

**\_\_\_ Bay Area** (Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara)

**\_\_\_ Central Valley** (Fresno, Inyo, Kern, Kings, Madera, Mariposa, Merced, Mono, San Joaquin, Stanislaus, Tuolumne, Tulare)

**\_\_\_ Central Coast** (San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Monterey, Ventura)

**\_\_\_ Los Angeles County**

**\_\_\_ Orange County**

**\_\_\_ San Diego** (San Diego, Imperial)

**\_\_\_ Inland Empire** (Riverside, San Bernardino)

**\_\_\_ Statewide** (Services are available to individuals regardless of their geographic location within California)

1. **\*What is your racial and ethnic identity?**

\_\_\_ American Indian / Native American / Alaskan Native

\_\_\_ Asian / Asian American

\_\_\_ Black / African American / African

\_\_\_ Hispanic / Latino

\_\_\_ Middle Eastern / North African

\_\_\_ Native Hawaiian / Pacific Islander

\_\_\_ White / Caucasian / European

\_\_\_ Mixed Race

\_\_\_ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Prefer not to answer

1. **Occupation** (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \***As a member, I would represent**:
3. Myself as an individual
4. Organization/Association (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **\*Membership Category – Please make a check on the line for the open membership category (or categories) for which you are applying. You may view the list of open positions on the** [**committee website**](https://www.chhs.ca.gov/home/committees/alzheimers-disease-and-related-disorders-advisory-committee/#meeting-information). (Check all that apply)

\_\_\_ Individual representing families of persons directly affected by Alzheimer’s disease or related conditions.

\_\_\_ Individual representing organization providing services to persons living with Alzheimer’s disease or related conditions.

\_\_\_ Individual representing the following experience:

\_\_\_ First responder (emergency medical

responder (EMRs), emergency medical technician (EMTs), paramedic, law enforcement, and firefighters)

\_\_\_\_ Primary care physicians

\_\_\_\_ Faith leaders

\_\_\_\_ Financial protection advocates

\_\_\_\_ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **\*Please provide a brief statement of qualifications that highlights the relevant skills and experience you would bring to the Alzheimer’s Disease and Related Conditions Advisory Committee.**
2. **\*Briefly describe the interests you will represent and what you hope to contribute by participating on the Alzheimer’s Disease and Related Conditions Advisory Committee.**
3. **\*What are the central issues related to Alzheimer’s and other dementias you would recommend the committee consider and why?**
4. **\*Committee members are expected to attend and actively engage in four (4) committee meetings per year held virtually and in person at the California Department of Aging offices in Sacramento. Meeting dates are posted on the** [**committee website**](https://www.chhs.ca.gov/home/committees/alzheimers-disease-and-related-disorders-advisory-committee/#meeting-information)**. Committee meetings are four (4) hours and include a lunch period. The meeting is open to the public. Will you be able to meet this expectation?**

\_\_\_ Yes

\_\_\_ No

Signature of the person completing this form. Typing in your full name below is considered equivalent to a signature.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Electronic signature is acceptable.

**Please submit the application using one of the following options:**

* **Online**: [ADRCAC Online Application](https://www.surveymonkey.com/r/CQP2P8Q)
* **By Email**: EngAGE@aging.ca.gov
* **By Mail:**

California Department of Aging

2880 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833

**Attn: DPRE: Master Plan for Aging**