Wyoming Developmental Disabilities Advisory Council Membership Application

Thank you for your interest in becoming part of the Developmental Disabilities Advisory Council!

The Developmental Disabilities Advisory Council (DDAC) exists by authority of W.S. 9-2-107(a) for the purpose of advising the Wyoming Department of Health, Home and Community-Based Services Section (Section) staff on formulating and amending rules, policies, and procedure relating to Section programs and activities. The purpose of DDAC is to assist and advise the Section in implementing a statewide service delivery system for persons who are identified as having developmental and intellectual disabilities, and acquired brain injuries (ABI).

DDAC is comprised of the following members, each of whom holds the position for three years:

- Two members of the Council shall be legally authorized representatives of a person with developmental disabilities, intellectual disabilities, or an ABI.
- One member of the Council shall be a self-advocate.
- Two members of the Council shall be Wyoming public or private providers of developmental disability, intellectual disability, or acquired brain injury services. One of which will be an independent provider.
- One member of the Council shall be a case manager providing services for a person with a developmental disability, intellectual disability, or an acquired brain injury.
- One member of the Council shall represent the Department of Education, Division of Special Education Programs.
- One member of the Council shall represent the Department of Workforce Services, Division of Vocational Rehabilitation.
- One member of the Council shall represent the Governor's Council on Developmental Disabilities (WGCDD).
- One member of the Council shall represent Protection & Advocacy System, Inc.
- One member of the Council shall represent the Wyoming Institute for Disabilities (WIND).
- One member of the Council shall be the Executive Director of the Wyoming Community Service Providers (WCSP).
- One member of the Council shall represent the Wyoming Department of Family Services (DFS).

DDAC meets four times per year. Attendance by conference call is permitted. DDAC members are appointed by the Director of the Wyoming Department of Health and serve without compensation. You may find a copy of DDAC's by-laws on the Section's website at: https://health.wyo.gov/healthcarefin/hcbs/hcbs-public-notices

To be considered for DDAC membership, please complete the following application and submit it to Kala Garcia at kala.garcia@wyo.gov, or mail the application to:

Wyoming Department of Health
Attn: Kala Garcia
122 W. 25th Street, 4 West
Cheyenne, WY 82002

If you have questions regarding DDAC or this application, please contact Kala Garcia kala.garcia@wyo.gov or call (307) 777-8761 or (800) 510-0280.

HOME & COMMUNITY-BASED SERVICES
WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

Wyoming Developmental Disabilities Advisory Council Membership Application

Full Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Home/Cell Phone: _____ Work Phone: _____

What is your interest in being on the DD Advisory Council?

What position are you applying to fill?

- ☐ Legal representative of a person with DD/ABI
- ☐ IDD/ABI Service Provider
- ☐ Direct Support Professional
- ☐ Self Advocate
- ☐ Case Manager

Occupation, profession, or position (please include employer's name):

Education (please list degrees, schools and dates):

Please provide a brief summary of your work experience:

Please list any Boards, Commissions or other organizations to which you currently belong, as well as offices held:

Please list any circumstances that may restrict your availability to serve, if any:
☐ Not Applicable

Please feel free to provide us with any additional information you believe would assist us in our appointment process. Use additional sheets if necessary. Letters of recommendation are welcome but are not a requirement.
☐ Additional pages attached

I certify that all information contained on this application is true and complete to the best of my knowledge. I understand any misrepresentations or falsifications may result in removal of appointment.

Signature_____ Date _____