

Thank you for your interest in applying as a part of the District Disability Services Advisory Council (DDSAC). The DDSAC is regulated by Iowa Code 231.

A council's composition must include nine members with at least 50 percent of members being individuals with disabilities or caregivers. The appointments will be for three-year staggered terms, which will expire on June 30 of each year.

Responsibility of the DDSAC Council will include:

- Identifying District Access Point Opportunities
- Addressing District Access Point Challenges
- Advising the District Access Point

DDSAC applications are due August 15, 2025 and members will be notified by September 2, 2025. DDSAC meeting dates and times will be determined by DDSAC member availability, with orientation occurring in October. Please send applications via e-mail to [jcameron@ecriowa.us](mailto:jcameron@ecriowa.us), mail to MHDS of the ECR DAP, 210 5<sup>th</sup> Ave NE, Independence, IA 50644, or fax to 319-334-7495.

If you would like assistance in completing this application, please contact [jcameron@ecriowa.us](mailto:jcameron@ecriowa.us) or 319-334-7450 and you will be contacted by a staff member to arrange a phone or face to face interview.

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## District 7 Disability Services Advisory Council Application

### Contact Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

Are you a person with lived/living experience? Lived/living experience is defined as personal knowledge gained through direct and/or firsthand experience with disability conditions. Please select one:

☐ Yes      ☐ No

Are you a caregiver? A caregiver is defined as someone who provides assistance and support to another person who needs help with daily tasks and activities due to illness, injury, disability, or aging. Please select one:

☐ Yes      ☐ No

If yes, what is the age(s) of the individual(s) that you support: \_\_\_\_\_

**Provide a personal statement addressing your interest as a member of the DDSAC (250 word limit)**

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## Employment / Volunteer Experience

Employee Organization: \_\_\_\_\_

Job Title: \_\_\_\_\_

Job Description: \_\_\_\_\_

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Describe your experience/education related to disability services: \_\_\_\_\_

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Detail your volunteer/council experience: \_\_\_\_\_

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_