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| Family Care Council  **Applicant Profile** | |
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| *ATTACH DIGITAL PHOTO* | | | ApPLICANT NAME: *iNSERT nAME* | | |
| Local Family Care COUNCIL: *Area \_\_\_* | | |
| Brief Biography | | |
| CONTACT Phone icon 816-555-0146  Email outline karlsson@example.com  Mailbox outline 1234 Strawberry Lane  Tallahassee, FL 32399 | | |
| Seat Interst Consumer – receiving APD services  Consumer – receiving APD services within 4 years  Consumer – on APD waiting list  Parent  Sibling  Grandparent  Legal Guardian | | |

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| What interests you most about the Family Care Councils (FCCs)? |
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| What skills or experience do you have that would assist the FCCs in meeting their mandated purpose detailed in [Section 393.502(7) of the Florida Statutes](http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=393.502&URL=0300-0399/0393/Sections/0393.502.html)? |
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| What role do you hope to play on the FCC? |
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| What do you hope to achieve within your term limit? |
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| Family Care Councils must meet at least 6 times a year. Are there any limitations that may prevent you from serving at full capacity? |
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| Per [Section 393.502(2)(a), F.S.](http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=393.502&URL=0300-0399/0393/Sections/0393.502.html), the above applicant is being recommended by a majority vote of the local FCC. The council voted and approved the applicant with vote recorded in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FCC minutes. |