PARTNERS IN POLICYMAKING
INFORMATION ABOUT THE PROGRAM

What Is Partners in Policymaking?

- The mission of the program is to create future leaders and advocates in the area of disabilities in New Mexico.
- A nationally based curriculum that has been replicated in different parts of the country and the world.
- Partners attend seven, two-day training sessions; the majority of the sessions occur in Albuquerque.
- Each session begins at 1:00 p.m. on Friday and concludes by 3:00 pm on Saturday.
- Partners are given brief assignments between sessions and also participate in a small group project.
- National and state leaders in the disability movement present various topics such as:
  - History of Disability and the Disability Rights Movement
  - Inclusive Education, Inclusive Community, Conflict/Resolution
  - Supported Employment, Supported Living
  - Federal Policy and Legislative Process
  - State Legislative Process and Current Issues
  - Community Organization and Local Advocacy

Who should apply?

You should consider applying if you have any of the following pertain to you:

- You are passionate about creating positive change in the area of disabilities.
- You want to become an advocate or leader in the area of disabilities.
- You are a self-advocate, family member, or community member with an interest in improving systems in New Mexico (at least 2/3 of group needs to consist of self-advocates/family members).
- You want to find out more about the value of inclusion.
When and Where?
Partners attend seven, two-day training sessions; the majority of the sessions will take place in Albuquerque. Each session begins at 1:00 p.m. on Friday and concludes at 3:00 p.m. on Saturday. Attendance of all seven sessions is required. The sessions will occur **August 2014 through March 2015** (taking a break in the month of December).

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<th>2014</th>
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<td>08/22 &amp; 08/23</td>
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<td>11/14 and 11/15 (Break in December)</td>
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What’s The Cost?
The cost of the training program is waived for participants who are selected to attend*. This includes registration for seven sessions, lodging, and meals, all arranged by the Partners in Policymaking staff. All participants will be offered overnight lodging (even participants from Albuquerque/Metro area) and a roommate will be assigned. New Mexico Partners in Policymaking is supported in part by the N.M. Department of Health-DDSD Division and the N.M. Developmental Disabilities Planning Council.

Need Assistance?
If you need assistance to complete this application, contact Lauriann King at laking@salud.unm.edu or 505-272-5304, by April 8, 2014 (one week prior to the deadline).

**Application Deadline:** April 15, 2014
Applications must be postmarked by midnight, April 15, 2014.

**Return to:** *New Mexico Partners in Policymaking*
Please print the application, **keep a copy for yourself**, and return before April 15, 2014.
Any questions may be directed to Lauriann King at (505)272-5304 at laking@salud.unm.edu, or Liaser Armstrong at (505)272-4715.

Important note: You will receive a notification of the receipt of your application. If you have not received notification of the receipt of your application by April 22, 2014, you need to contact us immediately because that means we have not received your application. Applicants will receive notification that they have been accepted into the program by the end of May 2014.

**Keep these first two information pages and mail back the application to:**
2300 Menaul Blvd. NE, Albuquerque, NM 87107, Attention: Liaser Armstrong

* Continuation of program is pending funding.
New Mexico Partners in Policymaking
2014-2015 SESSION APPLICATION*

* Application is only good for this session. If you have completed an application in the past, you will need to fill out a “Partner's Application Update” form by the deadline of 04/15/2014 to be considered for the 2014-2015 session.

RETURN THIS APPLICATION BY APRIL 15, 2014 TO:
NM Partners in Policymaking
2300 Menaul Blvd. NE, Albuquerque NM 87107,
Attn: Lauriann King.
For questions about the application contact Lauriann King at (505)272-5304 or email laking@salud.unm.edu

Name: ________________________________________________________________
Address: __________________________________________________________________________________________________________
City: ______________________ County: ___________________________ Zip Code: __________
Day Phone: ______________________ Evening Phone: __________________________
Date of Birth: ______________________ Age: ________ Occupation: __________________________
Marital Status: ______ Male ______ Female
_____ Caucasian _____ African American _____ Latin American _____ Native American
_____ Asian-Pacific ______ Other Origin: ________________________________
What Language(s) do you speak? __________________________
Are you 18 years old or older (all applicants must be 18 years old)? YES ☐ NO ☐
Do you have a guardian? YES ☐ NO ☐
If yes, list name and contact information below:
   Name: ____________________________
   Phone contact: __________________________
Who is filling out this application? ____________________________________________
If other than the applicant, who is filling out this application? ____________________
(NOTE: We can only receive applications directly from the applicant.)
PLEASE CHECK THE FOLLOWING CHOICES THAT APPLY TO YOU:
(Note: At least 2/3 of the selected group must be self advocates/family members.)

____ A person with a disability.
____ A person who works at an agency that serves individuals with disabilities.
   Name of agency: _______________________
____ A parent of a person with a disability.
   Age of Child/Children with disability _______________________
____ A family member, other than parent, of a person with a disability.
   Age of family member(s) with disability _______________________
   Describe relationship(s) (Sibling, spouse, etc.)
____________________________________________________________________________________________
______ Other (describe)
____________________________________________________________________________________________

If you are a self advocate or family member, please specify the disability (or disabilities) for yourself, child, or family member:
____________________________________________________________________________________________
____________________________________________________________________________________________

FOR COMMUNICATION PURPOSES ONLY:

Do you have access to a computer?  YES ☐ NO ☐

Do you have access to the internet?  YES ☐ NO ☐

APPLICATION QUESTIONS: Please answer all questions to follow that are applicable to you. If you need additional space for your answers please feel free to make attachments as necessary.

1. What do you hope to gain from Partners in Policymaking?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
2. Is there one specific issue, area of concern, or problem that encourages you to apply to this program?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

3. Please describe how disability affects your life, either personally or through a family member with a disability.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

4. What types of experiences have you had in advocating for people with disabilities? Please describe in detail, listing efforts in letter-writing, personal advocacy, public testimony, etc. (Note: If you do not have these experiences, still apply! Partners will offer these types of experiences.)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________


5. What is your vision for people with disabilities in New Mexico?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

6. What services are you or your child currently receiving? (For example: therapy, respite care, case management, vocational, etc.)
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

7. Please list involvement in organizations or civic groups and offices held. Note that this is not a requirement to apply. (For example: Arc, Board Member; PTA, President; etc.) Name of Organization
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
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____________________________________________________________________________
____________________________________________________________________________
8. Please describe what impact you want to make in the community and how you see yourself taking what you learn from Partners in Policymaking® back to your community.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

9. Is there anything else that is important for us to know about you?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

10. Please list 2 people who know of your interest in disability issues. (For example: employer, teacher, spiritual advisor, etc.) Please note that we may be contacting them for references.

    A) Name: __________________________  B) Name: __________________________

    Email Address: __________________________  Email Address: __________________________

    City: __________________________  City: __________________________

11. How did you learn about Partners in Policymaking?

   □ Partner who already graduated: __________________________

   □ Agency: __________________________

   □ Email from: __________________________

   □ Other: __________________________
Please answer the following questions to help us to be prepared for the session if you are selected. The answers to these questions are not considered as part of the application review process.

ACCOMMODATIONS

1. Please check the following accommodations you would need in order to participate:
   - Wheelchair access
   - Larger print. Font size: ________
   - Seating near front
   - Sign Language Interpreter
   - Language translation services. Language: ____________________________
   - Other (be specific): ______________________________________________

2. Do you currently have a personal care assistant for your daily living needs? YES □ NO □
   NOTE: The Partners program does not provide personal care attendant services. If you need a personal care assistant on a daily basis, your assistant will need to assist you during the Partners Program.

3. SPECIAL MEAL REQUESTS: Partners in Policymaking will make their best effort to accommodate meal accommodations but it is up to the participant to remind hotel staff to insure their needs are met. Partners in Policymaking cannot be responsibility for the modifications to meal requests. Please check the special meal requirements that apply:
   - Vegetarian
   - Vegan
   - Food allergies: _________________________
   - Other: ______________________________

4. HOTEL ACCOMMODATIONS: All selected participants will be offered lodging at a designated hotel at double occupancy including Albuquerque residents. It is recommended for all participants to stay at the hotel but it is not mandatory. Rooms are only available for participant (not their family members, friends, etc). Participants who select double occupancy will be placed in a room with a same sex participant. IMPORTANT NOTE: The Partners program does not provide on-site respite/child care or personal care attendant services.
DOUBLE OCCUPANCY ROOMS:

Would you stay at the hotel (it is recommended but not mandatory)? YES ☐ NO ☐

SINGLE ROOMS: Partners will only offer single occupancy rooms if a personal care will be staying with the participant or if a physician signs a note of “medical necessity” to have single occupancy.

Would a personal care attendant be staying with you? YES ☐ NO ☐

Do you anticipate a signed letter from your physician stating medical necessity for single room occupancy? YES ☐ NO ☐

You choose to stay in a single room but did not check either of the above, so you know that you will be responsible to half of the price of the room. YES ☐

ACCESSIBLE ROOM:

Would you require an accessible room? YES ☐ NO ☐

Please note any additional comments in regards to lodging:
______________________________________________________________________

If you are selected, check the following if you agree:

☐ I will allow Partners in Policymaking to distribute my email address to other Partners currently in the program.

☐ I will allow Partners in Policymaking to distribute my email address to Partners graduates.

☐ I will allow Partners in Policymaking to distribute my email address to interested state agencies with the intent to connect to leaders and advocates in New Mexico.

_______________________________________________________________
Signature of Applicant

_______________________________________________________________
Date
PERSONAL COMMITMENT

The Partners in Policymaking project requires a significant commitment of time and energy. Participation involves a two-day program per month from August 2014 to March 2015. Each month, simple homework is required to be completed and submitted at the next session. In addition, each participant must participate in a leadership project to be completed during the course of the year. Please consider your commitment to this program before applying.

1. I am **committed** to attending seven, two-day sessions: ___Yes ___No
2. I understand that attendance is **required**: ___Yes ___No
3. I am **committed** to completing monthly homework assignments: ___Yes ___No
4. I understand that completing the project is **required**: ___Yes ___No
5. I **understand** that this training is just for me, and I will only bring family members/children to the closing ceremony (However, if I need a personal care attendant, they can attend and the program will cover their meals and hotel accommodation). ___Yes ___No
6. I **understand** that this is considered a conference and I am responsible and liable for myself and my personal belongings: ___Yes ___No

**Partners in Policymaking is not an entitlement program.** Participation in the program is highly competitive and spaces are limited. If you are accepted to be a participant in the 2014-2015 class of Partners in Policymaking, it is expected that you will attend and actively participate in each and every session. Failure to fulfill the terms and conditions of this training program will result in your being asked to leave the program.

I have read and understand the foregoing admonishment and agree to govern myself accordingly.

Signature of Applicant _____________________________ Date: ________________

RETURN ENTIRE APPLICATION BY APRIL 15, 2014 TO:
NM Partners in Policymaking
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Attention: Liaser Armstrong

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**Thank you for your interest in Partners in Policymaking! Please feel free to share copies of this application with anyone who may be interested.**