



Santa Clara County Mental Health Services Act (MHSA)  
Stakeholder Leadership Committee (SLC)  
MEMBER APPLICATION



**Full Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

Title (if applicable): \_\_\_\_\_

Organization or Agency Affiliation (if applicable): \_\_\_\_\_

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

**Phone #:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**1. What is your primary system transformation interest (please select top three)?**

- Community Collaboration (CCR § 3200.060)
- Cultural Competence (CCR § 3200.100)
- Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120)
- Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5)
- Integrated Service Experience (CCR § 3200.190)

**2. What group(s) do you represent (please select all that apply)?** (CCR § 3200.270, § 3200.300, WIC § 5898)

- Client/Consumers of behavioral health services (youth, transition-age youth)
- Client/Consumers of behavioral health services (adults, older adults)
- Families of clients/consumers of behavioral health services
- Mental health and substance use services direct care provider
- Social services direct care provider
- Cultural competence and diversity professional/expert
- Disabilities advocate
- Education, describe: \_\_\_\_\_
- Health care, describe: \_\_\_\_\_
- Law enforcement, describe (Office of the Sheriff, City, etc.): \_\_\_\_\_
- Veterans and /or representatives from veterans organizations
- Other interests (faith-based, aging and adult services, youth advocacy, individuals served by MHSA programs, etc.), describe: \_\_\_\_\_

Applications must be submitted on or before January 22, 2018

3. **Age:**  16-24 years  25-59 years  60+ years  Decline to state

4. **What is your preferred language? (select ONE)**

English  Spanish  Cantonese/Mandarin  Vietnamese  
 Tagalog  Other: \_\_\_\_\_

5. **What is your ethnicity?**

Latino/Hispanic  African American  American Indian/Native American  
 Asian/Pacific Islander  Caucasian/White  Other: \_\_\_\_\_

6. **Gender assigned at birth:**  Male  Female  Decline to state

7. **Gender identity:**

Male  Female  Transgender  Genderqueer  
 Questioning  Decline to state  Other: \_\_\_\_\_

8. **Sexual orientation:**

Bisexual  Gay/Lesbian  Heterosexual  Queer  
 Questioning  Decline to state  Other: \_\_\_\_\_

9. **Do you have a disability or learning difficulty? (select all that apply)**

Difficulty seeing  Difficulty hearing  Physical/mobility disability  
 Learning disability  Developmental  Dementia  
 Chronic health condition  Decline to state  Other: \_\_\_\_\_

10. **Are you a Veteran?**  Yes  No  Decline to state

11. **Have you received behavioral health services?**

Yes  No  Decline to state

12. **Are you a family member of a client/consumer of behavioral health services?**

Yes  No  Decline to state

**Please return your completed application on or before January 22, 2018 via email, mail or fax to:**

Email: [Evelyn.Tirumalai@hhs.sccgov.org](mailto:Evelyn.Tirumalai@hhs.sccgov.org) Fax: (408) 885-5789  
Mail: BHSD Administration, 828 S. Bascom Avenue, Suite 200, San Jose, CA 95128

Applications must be submitted on or before January 22, 2018

**SEE PAGE 3 FOR ADDITIONAL QUESTIONS →**

