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

SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery

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: _____

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 October 8, 2018 via email, mail or fax to:

Email: 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 October 8, 2018

SEE PAGE 3 FOR ADDITIONAL QUESTIONS →

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1. **What is your experience working with clients/consumers, families and/or culturally diverse communities?**

2. **Please describe your interest in serving on the MHSA Stakeholder Leadership Committee (SLC)?**

3. **Please describe your experience working with organizations or agencies, such as boards, committees, workgroups, service providers, etc.?**

4. **Every individual has strengths to contribute, what are some of the strengths you would bring to the MHSA Stakeholder Leadership Committee?**

5. **Anything else that you would like to share about yourself?**

Thank you!