COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara
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: _____ **Zip Code of Residence:** _____

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 mental health services (youth, transition-age youth)
   - ☐ Client/Consumers of mental 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 August 31, 2020 via email. Pleases use the SUBMIT button at bottom of page 3:

or use Email: evelyn.tirumalai@hhs.sccgov.org **Fax:** (408) 885-5789
To complete the form by phone, please call (408) 401-6117 for immediate assistance

SEE PAGE 3 FOR ADDITIONAL QUESTIONS →

1. **Describe your experience as a client/consumer, family member or member of a culturally diverse community.**

2. **Please describe your interests 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.? Add community groups.**

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

5. **Please feel free to note anything else that you would like to share about yourself.**

Thank you!

SUBMIT