**APPLICATION FOR MENTAL HEALTH SERVICES ACT**

 **CONSOLIDATED PLANNING ADVISORY WORK GROUP**

**NAME: **

**CONTACT INFORMATION**

**ADDRESS:CITY:  ZIP: **

**PHONE:  FAX: **

**EMAIL: **



**THANK YOU VERY MUCH FOR YOUR INTEREST!**

**NAME:**

**Please check all characteristics or affiliations that apply to you:**

1. **I live in:** West County [ ]  Central County [ ]  East County [ ]
2. **I work in:** West County [ ]  Central County [ ]  East County [ ]
3. **I am:** A current consumer of: Contra Costa Mental Health Services [ ]

 Another County’s Mental Health Services [ ]

 Other Mental Health Services (Please describe): [ ]

A past consumer of: Contra Costa Mental Health Services [ ]

 Another County’s Mental Health Services [ ]

 Other Mental Health Services (Please describe):

[ ]

A family member of a child or transition age youth:

 currently receiving services from Contra Costa Mental Health [ ]

 currently receiving services from another county [ ]

 who received services in the past from Contra Costa Mental Health [ ]

 who received services in the past from another county [ ]

 other (please describe): [ ]

 A family member of an adult consumer:

 currently receiving services from Contra Costa Mental Health [ ]

 currently receiving services from another county [ ]

 who received services in the past from Contra Costa Mental Health [ ]

 who received services in the past from another county [ ]

 other (please describe): [ ]

 A member of an underserved cultural community (please identify): **[ ]**

1. **I have paid or volunteer experience in:**

Education [ ]  Peer or Family Support Services [ ]

Public Health/Healthcare [ ]  Mental Health [ ]

Substance Abuse Services [ ]  Homeless Services [ ]

Law Enforcement [ ]  Social Services [ ]

Military Service

Social Justice Advocacy Organization (specify): [ ]



Community Based or Non-profit Organization (specify): [ ]

Other (specify): [ ]

 

1. **I am affiliated with or representing**:

Contra Costa County Mental Health Commission [ ]

NAMI or other family member organization [ ]

An elected or appointed body (specify): [ ]



A faith-based community (specify): [ ]



A disability rights organization (specify): [ ]



Other community organization (specify) [ ]

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1. **OPTIONAL: With what racial, ethnic or cultural group(s) do you identify? (Check all that apply):**

Caucasian [ ]

Native American [ ]

African American [ ]

Latino [ ]

Asian/Pacific Islander [ ]

Multi-racial [ ]

Youth [ ]

Older Adult [ ]

LGBTQQI2-S [ ]

Socioeconomically disadvantaged [ ]

Other (specify): [ ]

1. **a. After reviewing all of the above characteristics and/or affiliations that may apply to you, which is the primary perspective or viewpoint that you feel you represent?**

**b. Which would be the secondary perspective or viewpoint that you feel you represent?**

**c. With which part(s) of the county do you mostly identify?**

West [ ]  Central [ ]  East [ ]

1. **Why are you interested in participating in the Consolidated Planning Advisory Workgroup?**

1. **Please describe the knowledge and/or experience that you have providing or receiving mental health services that you could bring to the Consolidated Planning Advisory Workgroup.**

1. **Please describe the knowledge and expertise that you could bring in the area of the needs and resources of the diverse cultures that comprise Contra Costa County.**
2. **Please describe any other knowledge or expertise that you could bring to this process.**

1. **Can you commit to attending monthly meetings on the first Thursday of each month from 3:00 P.M. to 6:00 P.M.?**

Yes [ ]  No [ ]

1. **Can you commit to participating in at least one additional Contra Costa Mental Health sub-committee, such as Children’s, Transition Age Youth, Adult, Aging and Older Adult, Innovation, Housing, Social Inclusion, Membership or Steering?**

Yes [ ]  No [ ]

1. **Is there anything else that you feel want to share?**

1. **Do you have any special needs or require reasonable accommodation in order to participate?**

**\**NOTE: IF YOU ARE SELECTED, YOUR AGENCY AFFILIATION AND/OR SELECTED CHARACTERISTICS MAY BECOME PUBLIC INFORMATION.***

**\*I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT. THIS ACKNOWLEDGEMENT IS ADVISORY ONLY, AND IS NOT A CONSENT TO RELEASE INFORMATION.**

**Electronic Signature **

**Date** Click here to enter a date.