



Mental Health Services Act (MHS) STEERING COMMITTEE MEMBER APPLICATION

Date: _____

Name: _____

Title (if applicable): _____

Organization (if applicable): _____

Address: _____

Phone #: _____ **E-mail:** _____

1. Which stakeholder representative seat are you applying for (select all that apply)?

- Client/Consumers (youth, transition-age youth)
- Client/Consumers (adults, older adults)
- Families of children, adults, and seniors clients/consumers
- Providers of mental health and substance use services
- Providers of social services
- Cultural competence and diversity
- Disabilities
- Education
- Health care
- Law enforcement
- Veterans and /or representatives from veterans organizations
- Other interests (faith-based, aging and adult services, youth advocacy, individuals served by MHS programs, etc.)

2. Age: <15 years 16-25 years 26-59 years 60+ years Decline to state

3. What is your preferred language? (select ONE)

English Spanish Cantonese/Mandarin Tagalog Other: _____

4. Race: American Indian/Alaska Native Asian African-American/Black

Caucasian/ White Native Hawaiian Other Pacific Islander

Other: _____ Decline to state

For more information about MHS and the MHS Steering Committee Roles and Responsibilities including current membership composition and past meeting materials, visit www.smchealth.org/bhrs/mhsa.

5. Ethnicity: (select all that apply)

Hispanic/ Central American Mexican South American Caribbean
Latino: Puerto Rican Other: _____

Non-Hispanic/ African Eastern European European Middle Eastern
Latino: Other: _____

Asian: Chinese Filipino Japanese Cambodian
 Korean Vietnamese Asian Indian/
South Asian Other: _____

Decline to state

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

Applications will be accepted on a continuous basis and reviewed twice a year in January and May.

Please return your completed application via email, mail or fax to:

Colin Hart
225 37th Avenue, 3rd Floor
San Mateo, CA 94403-4324
Fax: (650) 573-2841
Email: MHSA@smcgov.org

SEE PAGE 3 FOR ADDITIONAL QUESTIONS →

For more information about MHSA and the MHSA Steering Committee Roles and Responsibilities including current membership composition and past meeting materials, visit www.smchealth.org/bhrs/mhsa.

- 1. Please describe your interest in serving as an MHSA Steering Committee member?**

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

- 3. What is your experience working with communities of culturally diverse backgrounds?**

- 4. Every individual has strengths to contribute to a steering committee, what are some of the strengths you would bring to the Steering Committee?**