

**MHSA STEERING COMMITTEE REPRESENTATIVE  
CONSUMER/FAMILY MEMBER  
LETTER OF INTEREST**

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

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

**Phone #:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**What is your culture/ race / ethnicity?** \_\_\_\_\_

**Which age group do you belong to?**

**16 – 25** \_\_\_\_\_

**55 - 59** \_\_\_\_\_

**26 – 54** \_\_\_\_\_

**60 years and older** \_\_\_\_\_

**Are you a Consumer?** \_\_\_\_\_ **Are you a Family member of a consumer?** \_\_\_\_\_

**Please check the position you are applying for:**

\_\_\_\_\_ **Youth consumer**

\_\_\_\_\_ **Family member of a youth consumer**

\_\_\_\_\_ **Adult consumer**

\_\_\_\_\_ **Family member of an adult consumer**

\_\_\_\_\_ **Older adult consumer**

\_\_\_\_\_ **Family member of an older adult consumer**

**Are you interested in being:**

\_\_\_\_\_ **A Primary representative**

\_\_\_\_\_ **An Alternate representative**

\_\_\_\_\_ **Either**

**When are you available to attend meetings? (circle all that apply)**

**Monday through Friday: Morning                      Afternoon                      Evening**

**Saturday-Sunday: Morning                      Afternoon                      Evening**

**1. Please tell us about your experience working with other groups or individuals prioritizing improvements for your community.**

2. Please describe your experience working with organizations or agencies, such as boards, committees, workgroups, service providers, etc.? If you have not had experience, would you be willing to attend an orientation?
  
3. Please describe your understanding of the Mental Health Services Act (Proposition 63). If you are not familiar with the Act, would you be willing to attend training to learn about the Act?
  
4. Every individual has strengths to contribute. What are some of the strengths you would bring to the Steering Committee?
  
5. What is your experience working with diverse perspectives towards a common goal?
  
6. Please provide any additional information about your experience or background that you feel is relevant.

**Signature:** \_\_\_\_\_  
**Name (printed):** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Please return your completed application via mail, fax or email to:**  
**Julie Leung, Acting MHSA Program Manager**  
**Grantland L. Johnson Center for Health & Human Services**  
**7001-A East Parkway, Suite 800**  
**Sacramento CA 95823-2501**  
**Fax: (916) 875-4044**  
**Email: MHSA@SacCounty.net**  
**Attn: MHSA Steering Committee**

**Applications will be accepted on a continuous basis.**