**Commonwealth of Pennsylvania**

**Office of Mental Health and Substance Abuse Services**

**Application for Membership**

**Mental Health Planning Council Committees**

This application must be completed by all individuals seeking appointment to the Office of Mental Health and Substance Abuse Services (OMHSAS) Mental Health Planning Council. The Council’s committees, subcommittees and related workgroups are charged with providing advice to OMHSAS’ Deputy Secretary on a broad range of issues. Committee members help ensure that the Commonwealth’s public mental health and substance abuse system focuses on facilitating recovery and building resilience of individuals served. Committee members represent the geographic and cultural diversity of Pennsylvania. For more information about OMHSAS and the Mental Health Planning Council Committees, visit: [Mental Health Planning Council (pa.gov)](https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/Mental-Health-Planning-Council.aspx)

Applications will be accepted throughout the year. Appointments will be made annually in May. Applications must be received by March 31st for the annual review. Applications received after that date will be held for the following year’s review. In the event of a vacancy, appointments may be made at other times throughout the year. **Individuals who are appointed will be notified by letter.**

This application is made available by electronic means. Applicants are not allowed to modify, edit, or alter this application other than to include their answers to questions. If a conflict arises between a version of the application in the applicant’s possession and OMHSAS’ version of the application, OMHSAS’ version shall govern.

**Committee Member Expectations**

* Committees will meet at least four times per year, including one in-person and three virtual. Committee members are expected to attend the in-person meeting.
* Committee members are expected to read and respond to emailed requests from Committee Co-Chairs in a timely fashion.
* Committee members are expected to represent their broader constituency – not only themselves or their own family member(s)/organization(s) in their committee’s work.
* Members must have the ability to communicate with those whom they are representing. Members are expected to bring their constituents’ concerns to the committee and to report back to their constituents on the outcomes of the committee’s work.
* Committee members should have the time and ability to participate in additional workgroups throughout the year on an as-needed basis.

**Section I: Contact Information**

**Full Name of Applicant:** Click here to enter text.Title (if applicable): Click here to enter text.

Preferred Name: Click here to enter text.

Preferred Pronouns: Click here to enter text.

Organization (if applicable): Click here to enter text.

Regional/Local Community Support Programs (CSP) (if applicable): Click here to enter text.

I will represent the above-mentioned organization or Community Support Program (CSP) in MHPC committee work\*: [ ]  Yes [ ]  No

***\*If you selected “yes” to the above question and would represent your organization or CSP as a member of MHPC, you must submit a letter of recommendation from your organization’s supervisor or CSP leadership as part of your application. The letter of recommendation must indicate that the organization or CSP supports you acting as a representative of the organization or CSP.***

**Applicant’s Contact information:**

Street Address: Click here to enter text.

City: Click here to enter text. State: Click here to enter text.

Zip Code: Click here to enter text. County: Click here to enter text.

Phone Number: Work Click here to enter text. Cell: Click here to enter text.

Home: Click here to enter text.

Email Address\*\*: Click here to enter text.
(For office use only) Region: Click here to enter text.

***\*\*Required to receive regular Council and Committee-specific notices, documents, and information.***

**Section II: Demographic Information**

*The following information is used to ensure that planning council membership reflects the demographic diversity of individuals receiving public mental health and substance abuse services in Pennsylvania. Demographic totals for the planning council are included in federal reporting; however, all information is de-identified.* ***OMHSAS does not release identifying information.***

Year in which you were born: Click here to enter text.

Please indicate your military background:

|  |  |
| --- | --- |
| [ ]  Veteran of the Armed Services  | [ ]  Active Duty  |
| [ ]  Active Reserves | [ ]  Other Click here to enter text. |
|  |  |

Gender with which you most identify:

|  |  |
| --- | --- |
| [ ]  Female | [ ]  Transgender Female  |
| [ ]  Male | [ ]  Transgender Male  |
| [ ]  Non-Conforming | [ ]  Self-Identify Click here to enter text. |

|  |  |
| --- | --- |
|  |  |

Sexual orientation with which you most identify:

|  |  |
| --- | --- |
| [ ]  Asexual | [ ]  Lesbian  |
| [ ]  Bisexual | [ ]  Queer  |
| [ ]  Gay | [ ]  Questioning  |
| [ ]  Straight (heterosexual) | [ ]  Intersex |
| [ ]  Prefer not to answer | [ ]  Self-Identify Click here to enter text. |

Ethnicity and Race (Check all that apply.):

|  |  |
| --- | --- |
| [ ]  American Indian or Alaska Native | [ ]  Native Hawaiian or Other Pacific Islander  |
| [ ]  Asian | [ ]  Hispanic/Latina/Latino  |
| [ ]  Black or African American | [ ]  White |
| [ ]  Unknown | [ ]  Self-Identify ­Click here to enter text. |

**Section III: Prior Experience**

*Please check all areas in which you have had some experience.*

[ ]  Mental Health Services

[ ]  Drug & Alcohol Services

[ ]  Co-Occurring Mental Health & Substance Use Disorders

[ ]  Multiple/Cross Disabilities

[ ]  Autism, Pervasive Developmental Disorder

[ ]  Aging

[ ]  Gay, Lesbian, Bi-sexual, Transgender, Queer, Questioning, Intersex

[ ]  HealthChoices Managed Care

[ ]  Fee for Service

[ ]  Medicare

[ ]  Housing

[ ]  Career/Employment Services

[ ]  Juvenile Justice

[ ]  Adult Justice System

[ ]  Transition Issues

[ ]  Education System

[ ]  Brain Injury

[ ]  Deaf/Hard of Hearing

[ ]  Deaf/Blind

[ ]  Blind or Visually Impaired

[ ]  Veterans/Active Military

[ ]  Transition Age Youth (age 16-30)

[ ]  Minority Cultural Diversity: Click here to enter text.

[ ]  Other: Click here to enter text.

**Additional Past Experience:**

*Please describe your previous involvement in local/regional/statewide efforts (work groups, other associations, coalition, etc.) and relevant work and personal experience.*

Click here to enter text.

**Section IV: Planning Council Interest**

**Mental Health Planning Council Background:**

[ ]  I am a former OMHSAS Mental Health Planning Council member reapplying for a new term.

*(Member during what years? From Click here to enter text. To Click here to enter text.)*

[ ]  I have never been a member of an OMHSAS Mental Health Planning Council.\*\*\*

*\*\*\*Individuals are encouraged to attend at least one Council meeting prior to applying for membership. Council meetings are open to the public and you can receive information on attending by joining the* [*OMHSAS GENERAL LISTSERV*](http://listserv.dhs.pa.gov/omhsas_general_listserv.html) *and select “Join or leave the list”.*

**I am applying for membership on the following Committee:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **1st choice**  | **2nd choice**  | **3rd choice** |
| Children’s Committee  |[ ] [ ] [ ]
| Adult Committee  |[ ] [ ] [ ]
| Older Adult Committee  |[ ] [ ] [ ]

**Membership Categories:**

In the first column, please select all membership categories that apply to you. Individuals most often fit into multiple membership categories. In the second column, if you have lived experience in any of the categories below, please select the **one** you identify with the most.

|  |  |  |
| --- | --- | --- |
| MembershipCategories **(Select all that apply)** | Lived Experience (**Select no more than one.**)  |  |
|[ ] [ ]  Current/ former recipient of adult mental health services |
|[ ] [ ]  Current/ former recipient of children’s mental health services |
|[ ] [ ]  Current/ former recipient of adult drug & alcohol services |
|[ ] [ ]  Current/ former recipient of youth drug & alcohol services |
|[ ] [ ]  Primary Caregiver of a child who is a current/ former recipient of mental health services. *Date of Birth of Identified Child:* Click or tap here to enter text.[ ]  Parent [ ]  Grandparent [ ]  Foster Parent [ ]  Other |
|[ ] [ ]  Primary Caregiver of a youth who is a current/ former recipient of drug & alcohol services. *Date of Birth of Identified Child:* Click or tap here to enter text.[ ]  Parent [ ]  Grandparent [ ]  Foster Parent [ ]  Other  |
| [ ]  |[ ]  Family member of an adult who is a current/ former recipient of mental health services |
|[ ] [ ]  Family member of an adult who is a current/ former recipient of drug & alcohol services |
|[ ] [ ]  Advocate |
|[ ]   | Professional in the mental health/drug and alcohol service system (select below) |
|  |  | [ ]  County  | [ ]  Trainer |
|  |  | [ ]  Provider | [ ]  Other (specify) Click here to enter text. |
|  |  | [ ]  Employee of a Pennsylvania State department/office/program |

**Statement of Interest:**

*Please provide a paragraph detailing your interest in planning council membership.*

Click here to enter text.

**Section V: Additional Requirements**

**Letter of recommendation:**

* *A letter of recommendation, although not required, is strongly recommended for all applicants.*
* ***A letter of recommendation is REQUIRED to be considered an official representative of an organization and/or a regional/local Community Support Program (CSP).***

**Phone Interview:**

*A brief phone interview with an OMHSAS Staff Member and Planning Council Co-Chair may be required as part of the selection process.*

**Completing this Application:**

To be considered for appointment/reappointment, applicants must complete all sections of this application. Contact OMHSAS at RA-PWOMHSASMHPC@pa.gov with any questions or concerns, for assistance in completing this form, or to request that the form be provided in a different format or language.

***Deadline to submit membership application is close-of-business MARCH 31, 2024.***

**Please submit your completed application to:**

**Mail: Mental Health Planning Council Lead Staff**

**Commonwealth of Pennsylvania**

**DHS-OMHSAS**

**Commonwealth Tower 11th Floor**

**P.O. Box 2675**

**Harrisburg, PA 17105-2675**

**Email:** RA-PWOMHSASMHPC@pa.gov

**Fax: 717-772-7964, Attn: MHPC Lead Staff**

***Thank you*** *for your interest in becoming a member of OMHSAS’ Mental Health Planning Council!*

|  |
| --- |
| ADMINISTRATIVE USE ONLY |
| Date & Initial |
|  |  |  |  |  |  |  |  |
| Received | DataBase | ListServ | Appt | Term | Letter | Handbook | MHPC |