MADERA COUNTY
BEHAVIORAL HEALTH BOARD

P.O. Box 1288
Madera, CA 93639-1288
(559) 673-3508
FAX (559) 675-4999

Membership Application Form

1. NAME: ______________________________ PHONE: ____________________

   HOME ADDRESS: ____
   Street City State Zip

   EMAIL ADDRESS: ____

2. EMPLOYMENT:

   ________ Full Time ________ Part Time
   ________ Retired ________ Self-Employed
   ________ Unemployed ________ Student

   Occupation: ____

   Employer: ______________________________ Phone: ________________

   Work Address: ____

3. Madera County Board of Supervisor's District: ______________________

4. Why do you wish to serve on the Behavioral Health Board?

   Mental Health Issues as Primary Reason ☐ AOD Issues as Primary Reason ☐

   Please explain: ____

   ____

   ____

5. SUMMARY OF APPPLICABLE EXPERIENCE (Job-related, personal life, volunteer, community service, advisory boards, etc. You may attach a resume.)

   ____

____

6. Are you able to contribute at least 4 hours per month to the Behavioral Health Board?

   Yes ☐ No ☐

7. ORGANIZATION AND BOARD AFFILIATIONS: (List all professional or community organizations to which you now belong.)

   ____

   ____

8. Do you need transportation assistance to attend meetings? Yes ☐ No ☐

9. The Behavioral Health Board aims to reflect the ethnic diversity of the client population in the County. The following information is voluntary, but it does assist in ensuring that the Board is representative of the Community. Ethnicity:

   African American ☐ Asian ☐ Caucasian ☐ Latino ☐ Native American ☐ Other ☐

10. State law mandates that this Board is comprised of a minimum of ten (10) individuals that cite mental health issues as their primary reason for serving on the Board. Fifty percent (50%) of that category of Board membership must be consumers or the parents, spouses, siblings or adult children of consumers who are receiving or have received mental health services. At least 20% of the total membership shall be consumers, and at least 20% shall be families of consumers.

    Please be advised that this document is public record. If you are willing, please identify what best describes your category of membership:

    General public ☐

    Direct consumer of mental health services ☐ ______________________________
    (Past or Present)

    Parent, spouse, sibling or adult child of a current or past recipient of mental health services

    ☐ ____
    (Relationship)

11. Are you or your spouse a full-time or part-time employee of the State Department of Mental Health?

    ☐ ☐

Yes No

12. Are you or your spouse an employee or a paid member of the governing body of a Bronzan-McCorquedale contract agency?

Yes ☐ No ☐

Signed: ________________________________ Date: ________________________