



Oregon Health Authority / Addictions and Mental Health Division
Children's Statewide Wraparound Initiative Advisory Committee/
Children Systems Advisory Committee (CSAC)
Youth Membership Application

Date: _____

Applicant Name: _____

Mailing Address: _____

Telephone: _____ Fax: _____

Email: _____

I am interested and eligible to serve on CSAC as a (if more than one, please indicate your top three choices):

- Young Adult who is receiving (or has received) behavioral health services
Family member of children/youth with a serious emotional disorder who is receiving (or has received) mental health services
Foster family
Family member of children/youth with a substance use disorder who is receiving (or has received) addictions services
Advocate/natural supports/community partners - Agency Name (if applicable):
Representative of a Federally Recognized Tribe - Name of Tribe:
Service Provider - Agency Name:
Alcohol & Drug Program for adolescents
Alcohol & Drug Program for families
Child Welfare (Field)
Child Welfare (Policy)
Community-based prevention or early intervention program
Community Mental Health Program

- Coordinated Care Organization (rural)
- Coordinated Care Organization (urban)
- County Juvenile Justice
- Department of Education
- Developmental Disabilities/ Intellectual Disability (children's programs)
- Early Childhood system
- Local Education or Educational Services Departments
- Oregon Children's Alliance
- Oregon Council of Child and Adolescent Psychiatry
- Oregon Youth Authority
- Oregon Family Support Network
- Oregon Consumer Advisory Council
- Portland State University/ Research & Training
- Primary Care
- Residential Treatment Facility/Program
- Youth M.O.V.E.-Oregon

Advocate/Support/Community Partner – Agency Name (if applicable): _____

Member-at-large – Agency Name (if applicable): _____

1. Members of the Committee agree to actively participate in at least one subcommittee identified in the yearly CSAC work plan. In 2015, this includes workgroups on addressing issues and systemic barriers to Young Adult Engagement, Suicide Prevention Plan, Family/Youth Support Workforce and Early Childhood.

2. Please describe why you would like to become a member of CSAC.

Please share your involvement in local, regional or national planning and/or organizational committees:

3. Please describe how and to whom you would take information from CSAC back to and share:

4. Please share your involvement of services for children or young adults:

5. Please describe the skills, knowledge and strengths that you bring to CSAC.

6. Is there anything else you would like us to know about you?

7. Are you able to attend regularly scheduled meetings in Salem yes no

8. Will you need assistance with translation, accommodation, or signing? yes no

9. CSAC and its subcommittees value and seek to actively promote diverse, inclusive participation by officers and members. As such we request the following demographic information. This information is completely voluntary and will not be shared. Please indicate your age by choosing one of the following categories:

- Under 18
- 18-24
- 25-34

- 45-54
- 55-64
- 65+

Please indicate how you self-identify racially:

- American Indian or Alaska Native
- Asian
- Black, African
- Black, Caribbean
- Black, African-American

- Native Hawaiian or other Pacific Islander
- White
- Decline to Answer
- Unknown

If you identify with more than one race, which one of the following do you consider your primary race identity?

- American Indian or Alaska Native
- Asian
- Black, African
- Black, Caribbean
- Black, African-American

- Native Hawaiian or other Pacific Islander
- White
- Decline to Answer
- Unknown

Please indicate how you identify ethnically (check all that apply):

- Latino/Hispanic
- Not Latino or Hispanic
- Decline to Answer

- Unknown
- Other (Please specify):

If you are an immigrant or refugee, please indicate your country of origin:

If you are an immigrant or refugee, how long has your family lived in the US?

- 1st generation
- 2nd generation
- 3rd generation or longer

Please indicate your preferred spoken language:

- | | |
|---|--|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Lao/Laotian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Mandarin |
| <input type="checkbox"/> Bosnian | <input type="checkbox"/> Mien |
| <input type="checkbox"/> Burmese | <input type="checkbox"/> Romanian |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Chinese (other) | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> English | <input type="checkbox"/> Somali |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Teochew |
| <input type="checkbox"/> Hmong | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Khmer (Cambodian) | <input type="checkbox"/> Other (Please specify): |
| <input type="checkbox"/> Korean | _____ |

10. Committee members are expected to be present for the majority of all scheduled CSAC meetings, which includes active participation on subcommittees when needed. Your signature on this application indicates your willingness, desire and ability to serve on the Committee, if appointed.

Signed: _____ Date: _____

We thank you for your interest. **Send completed membership application to:**

Frances Purdy
Family Partnership Specialist
OHA Addictions & Mental Health Division
ATTN: CSAC Application
500 Summer St NE, E-86
Salem, OR 97301

If you have any questions about CSAC, its subcommittees or the application process, please call Frances Purdy at 503-957-9863 or email her at frances.s.purdy@state.or.us