Santa Clara County
Mental Health Department
Mental Health Services Act (MHSA)
Stakeholder Comment Form

MHB Older Adult Committee July 8, 2013 Meeting

PLEASE TELL US ABOUT YOURSELF

What is your age?
- ☐ 0-15 yrs
- ☐ 16-24 yrs
- ☐ 25-59 yrs
- ☐ 60+ yrs

What is your gender?
- ☐ Male
- ☐ Female
- ☐ Other_____

What group do you represent? (Check All that Apply)
- ☐ Family Member of Consumer
- ☐ Consumer of Mental Health Services
- ☐ Social/Human Service Provider
- ☐ Law Enforcement
- ☐ Community Agency
- ☐ Mental Health Provider
- ☐ School Personnel
- ☐ Community Member
- ☐ Substance Use Provider
- ☐ Faith Community
- ☐ County Staff
- ☐ Health Provider

What is your ethnicity?
- ☐ Latino/Hispanic
- ☐ African American
- ☐ American Indian/Native American
- ☐ Asian/Pacific Islander
- ☐ Caucasian/White
- ☐ Other_____

What is your primary system transformation interest?
- ☐ Recovery and Resiliency Focused Services
- ☐ Cultural and Ethnic Competency and Equity
- ☐ Family and Consumer Driven Services
- ☐ Influence on Other Systems (Law Enforcement, Social Services, Health, Faith, etc.)
- ☐ Community/Public Education, Prevention, Stigma and Discrimination, etc.

PLEASE PROVIDE COMMENT/FEEDBACK BELOW:

Thank you for taking the time to provide your input.

Your Voice Matters!

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM