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

MHB Family, Adolescent & Children's Committee July 11, 2013

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