SANTA CLARA COUNTY
Behavioral Health Services

FISCAL YEAR 2021
Mental Health Services Act's Workforce Education and Training Program

Agency: _____

I am interested in the: ☐ Peer Internship ☐ Family Member Internship

Please type or print legibly.

_____
First Name Middle Initial Last Name

_____
Current Address City State Zip

_____
Permanent Address City State Zip

E- Mail Address: _____ Cell Number: _____

Home Phone Number: _____ Best Phone # to contact you: _____

Language Skills and Proficiency (Other than English): Please rate proficiency on a scale of 1 (low) to 5 (high).
Language:_____ _____ Speak Language:_____ _____ Speak
You may be required to pass a proficiency test.

Highest Level of Education Completed: _____

Additional Training or Certifications: _____

Prior Experience: (please describe any relevant work or volunteer experience you have had; you may include responsibilities that you have managed in your home life).

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STIPEND APPLICATION FOR PEER/FAMILY MEMBER INTERN PROGRAM
Mental Health Services Act's Workforce Education and Training Program

Briefly respond to the two questions listed below (200 words or less for each question). You may write below, or attach a response.

1. Why are you interested in working in the Mental Health Field?

2. The driving philosophy to transform the Public Mental Health System is based on concepts of "Wellness and Recovery." Consumers learn to live and manage their mental health through a strength-based, self-directed and peer supported approach. What is your opinion and/or experience about the ability of consumers to develop meaningful roles in life with the use of this model?

3. As a condition of funding for this position it is required that the incumbent either be a consumer of mental health services or a family member/caregiver of a consumer. Please describe how you have obtained life experience as a consumer of mental health services or a family member/caregiver of a consumer?

I certify that the answers I have given in my application are true and correct to the best of my knowledge, and that I have not knowingly withheld any facts or circumstances. I understand that all responses are subject to verification and any incorrect information will result in my application being disqualified.

Signature: _____ Date: _____

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(Your email address will be considered as your electronic signature)

Applicants must submit the following information: *Agency Staff Only*

☐ Application with approval by agency for internship program Score: _____

Agency Name: _____ Contact Person: _____