# **Behavioral Health Planning Council (BHPC)**

**Minnesota Mental Health and Substance Abuse Federal Block Grant**

**Membership Application**

A completed membership application must be submitted via email, fax or mail (email is preferred). Note all applications will be reviewed by a review committee that consists of the Alcohol and Drug Abuse Division and Mental Health Division staff. Please print clearly.

For electronic submissions: click and type in each section that states “Click here to enter text”. To select a check box, click on the box and an “X” will appear on the box checked.

**Name:** Click here to enter text.

**Home Address:** Click here to enter text.

**City:** Click here to enter text.

**State:** Click here to enter text.

**Zip Code:** Click here to enter text.

**County:** Click here to enter text.

**Telephone:** Click here to enter text.

**E-mail:** Click here to enter text.

## **Demographic Information** (the following section is optional)

**Gender**

[ ] Female

[ ] Male

[ ] Other

**Age:** Click here to enter text.

**Race/Ethnicity** (Check all that apply)

[ ]  Black or African American

[ ] African

[ ] American Indian/Native American (please specify tribal affiliation): Click here to enter text.

[ ] Alaska Native

[ ] Asian

[ ] Native Hawaiian/Pacific Islander

[ ] Latina/Latino

[ ] Hispanic

[ ] White or Caucasian

[ ] Other (please specify): Click here to enter text.

**Country of Origin:** Click here to enter text.

## **BHPC Membership Composition**

**The Behavioral Health Planning Council has the following goals to assure membership is comprehensive and meets the federal requirements.**

* 51 % or more of the membership will be persons with lived experience of mental health, persons in recovery from substance use disorders, family members, and advocacy organizations
* 49 % of less of the membership will be providers, state agencies and federally recognized tribal representatives
* Equal representation of substance abuse and mental health
* Balanced representation of prevention, treatment and recovery
* Balanced regional representation (urban, rural, northern/greater MN and frontier)
* Balanced representation of race, ethnicity, age and gender
* Balanced representation across children, adolescents, young adults and adults

## **Supplemental Questionnaire**

**Please answer the following supplemental questions to the best of your ability. Your supplemental questionnaire will be scored by the review committee based on the responses you provide. Please insure your information is accurate and complete.**

1. Please give a brief description of your current and past experience with mental health, substance use disorder and/or behavioral health.

Click here to enter text.

1. Please identify key skills, strengths and knowledge that you would bring to the BHPC.

Click here to enter text.

1. Please list your involvement with mental health, substance use disorder and/or behavioral health, including your experience, training and involvement with underrepresented and underserved communities.

Click here to enter text.

1. The BHPC will have quarterly meetings (4-5 meetings annually). Will you commit to attending all meetings?

Click here to enter text.

Please check only one category you intend to primarily represent in column one, which is labeled “Primary”. Check all categories that you can also represent in column two, which is labeled “Secondary”. By checking the boxes in column one and/or two you are agreeing to being identified as a representative in those categories.

**Persons with Lived Experience of Mental Health, Persons in Recovery from Substance Use Disorder, Families, Advocacy Organizations**

For Persons with Lived Experience of Mental Health, Persons in Recovery from Substance Use Disorder, Families, Advocacy Organizations (51 % of more of the BHPC membership).

| **I am an Individual or Family member from diverse racial, ethnic, and/or LGBTQ populations.** | Yes [ ]  | No [ ]  |
| --- | --- | --- |

| **Representative Categories** | **Primary** (Select one that you will primarily represent) | **Secondary** (Select all that you can also represent) |
| --- | --- | --- |
| Adult with lived experience of Mental Health  |[ ] [ ]
| Adult in recovery from or at risk of substance use disorder |[ ] [ ]
| Youth/Young Adult with lived experience of Mental Health |[ ] [ ]
| Youth/young adult in recovery from or at risk of substance use disorder |[ ] [ ]
| Family Member of an Adult with lived experience of mental health  |[ ] [ ]
| Family Member of an Adult in recovery from or at risk of substance use disorder  |[ ] [ ]
| Parent/guardian of a child/youth/young adult with lived experience of Serious Emotional Disturbance (SED) |[ ] [ ]
| Parent/ guardian of a child/youth/young adult in recovery from or at risk of substance use disorder  |[ ] [ ]

| **Advocacy Organizations**  | **Primary** (Select one that you will primarily represent) | **Secondary** (Select all that you can also represent) |
| --- | --- | --- |
| Mental Health Advocacy Organization **Please specify:** Click here to enter text. |[ ]  ☐ |
| Substance Use Disorder Advocacy Organization **Please specify**: Click here to enter text. |[ ]  ☐ |
| Community Prevention Coalition or Advocacy Organization **Please specify:** Click here to enter text. |[ ]  ☐ |

**Providers, State Agencies and Federal Recognized Tribal Representatives**

For Providers, State Agencies and Federal Recognized Tribal Representatives (49 % or less of the BHPC membership).

| **I am Provider from diverse racial, ethnic, and/or LGBTQ populations.** | Yes [ ]  | No [ ]  |
| --- | --- | --- |

| **Representative Categories**  | **Primary** (Select one that you will primarily represent) | **Secondary** (Select all that you can also represent)  |
| --- | --- | --- |
| Mental Health Provider  |[ ] [ ]
| Substance Use Disorder Provider  |[ ] [ ]
| Mental Health Prevention Provider  |[ ] [ ]
| Substance Use Prevention Provider  |[ ] [ ]
| Culturally Specific Mental Health Provider or Organization  |[ ] [ ]
| Culturally Specific Substance Use Disorder Provider or Organization  |[ ] [ ]
| Provider of Mental Health Services to LGBTQ and underserved Communities  |[ ] [ ]
| Provider of Substance Use Services to LGBTQ and underserved Communities  |[ ] [ ]

**State Agency and American Indian Tribal Representatives**

| **Representative Categories**  | **Primary** (Select one that you will primarily represent) | **Secondary** (Select all that you can also represent)  |
| --- | --- | --- |
| Department of Human Services Representative (CSA Assistant Commissioner) |[ ] [ ]
| Department of Education Representative  |[ ] [ ]
| Department of Employment and Economic Development Representative  |[ ] [ ]
| Minnesota Housing Finance Agency Representative (Housing) |[ ] [ ]
| Department of Corrections Representative  |[ ] [ ]
| Federally Recognized Tribal Representative  |[ ] [ ]

**Applicant Signature:** Click here to enter text. **Date:** Click here to enter a date.