

## Commonwealth of Pennsylvania Office of Mental Health and Substance Abuse Services Application for Membership on Mental Health Planning Council Committees

This application must be completed by all individuals seeking appointment - or reappointment - to a committee on the Office of Mental Health and Substance Abuse Services (OMHSAS) Mental Health Planning Council. The Council's committees, subcommittees and related workgroups are charged with providing advice to OMHSAS' Deputy Secretary on a broad range of issues. Committee members represent the geographic and cultural diversity of Pennsylvania, and help ensure that the Commonwealth's public mental health and substance abuse system focuses on facilitating recovery, building resilience and wellness of individuals served. For more information about OMHSAS and the Mental Health Planning Council Committees, visit: [www.parecovery.org](http://www.parecovery.org).

Applications will be accepted throughout the year. Appointments/reappointments will be made annually in May. In the event of a vacancy, appointments may be made at other times throughout the year. **Individuals who are appointed or reappointed will be notified by letter.**

### Committee Member Expectations

- Committees will meet at least four times per year in the Harrisburg region. Committee members are expected to physically attend at least three of these meetings annually. Members without state/agency funding may request travel cost reimbursement through OMHSAS.
- Committee members are expected to read and respond to e-mailed requests from Committee Co-Chairs in a timely fashion.
- Committee members are expected to represent their broader constituency – not only themselves or their own family member(s)/ organization(s) - in their committee's work.
- Members must have the ability to communicate with those they are representing to bring their concerns to the committee and to report back on the outcomes of the committee's work.
- Committee members should have the time and ability to participate in additional workgroups throughout the year on an as-needed basis.

### Section I: Contact Information

**Full Name of Applicant:** \_\_\_\_\_ **Title (if applicable):** \_\_\_\_\_  
**Preferred Name:** \_\_\_\_\_ **Preferred Pronouns:** \_\_\_\_\_  
**Organization (if applicable):** \_\_\_\_\_  
**Regional/local committee representative (if applicable):** \_\_\_\_\_

I will represent the above organization/committee in committee work\*:    Yes        No

*\*A letter of recommendation from the organization/committee is required for an individual to formally represent the organization/ committee on the Mental Health Planning Council.*

#### **Applicant's Contact information:**

**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_  
**Zip Code:** \_\_\_\_\_ **County:** \_\_\_\_\_  
**Home Phone Number:** \_\_\_\_\_ **Cell Phone Number:** \_\_\_\_\_  
**Email Address\*\*:** \_\_\_\_\_ (For office use only: \_\_\_\_\_ region)

*\*\*Required to receive regular Council and Committee-specific notices, documents, and information.*

## Section II: Planning Council Interest

### Mental Health Planning Council Background:

I am a current OMHSAS Mental Health Planning Council member reapplying for a new term.

I am a former OMHSAS Mental Health Planning Council member reapplying for a new term.

(Member during what years? From \_\_\_\_\_ to \_\_\_\_\_.)

I have never been a member of an OMHSAS Mental Health Planning Council.\*\*\*

\*\*\*Individuals are encouraged to attend at least one Council meeting prior to applying for membership.

### I am applying for membership on the following Committee:

1<sup>st</sup> choice    2<sup>nd</sup> choice (optional)

Children's Committee

Adult Committee

Older Adult Committee

### Membership Categories:

Please select all membership categories that apply to you.

Although individuals most often fit into multiple membership categories, a primary category must be identified for reporting purposes. Please also select the **one category** you prefer to represent as a member of the OMHSAS Mental Health Planning Council.

Select all  
that apply    Primary

Current/ former recipient of mental health services (adult representative)

Current/ former recipient of mental health services (youth representative)

Current/ former recipient of drug & alcohol services (adult representative)

Current/ former recipient of drug & alcohol services (youth representative)

Parent of a child\* who is a current/ former recipient of mental health services

Parent of a child\* who is a current/ former recipient of drug & alcohol services

Family member of an adult who is a current/ former recipient of mental health services

Family member of an adult who is a current/ former recipient of drug & alcohol services

Advocate

Professional in the mental health/drug and alcohol service system (select below)

County Employee            Trainer

Provider                      Employee of a Pennsylvania State department/office/program

Other (specify):

\*At the time of this application, how old is your child?

### Statement of Interest:

Please provide a paragraph explaining your interest in planning council membership.

### Section III: Prior Experience

Please check all areas in which you have had some experience.

- |  |                                  |
|--|----------------------------------|
| Mental Health Services   | Career/Employment Services       |
| Drug & Alcohol Services  | Juvenile Justice                 |
| Co-Occurring Mental Health & Substance Use Disorders               | Adult Criminal Justice System    |
| Multiple/Cross Disabilities  | Transition Issues                |
| Autism, Pervasive Developmental Disorder                           | Education System                 |
| Aging  | Brain Injury                     |
| Gay, Lesbian, Bi-sexual, Transgender, Queer, Questioning, Intersex | Deaf/ Hard of Hearing            |
| HealthChoices Managed Care   | Deaf/ Blind                      |
| Fee for Service  | Blind or Visually Impaired       |
| Medicare   | Veterans/ Active Military        |
| Housing  | Transition Age Youth (age 16-30) |
|  | Minority Cultural Diversity:     |
|  | Other:                           |

#### Additional Past Experience:

Please relate previous involvement in local/regional/statewide efforts. (Include OMHSAS work groups, other associations, coalitions, etc.) Additional page may be attached.

### Section IV: Demographic Information

The following information is used to ensure that planning council membership reflects the demographic diversity of individuals receiving public mental health and substance abuse services in Pennsylvania. Demographic totals for the planning council are included in federal reporting, however all information is de-identified. **OMHSAS does not release identifying information.**

Year in which you were born: \_\_\_\_\_

Please describe your military background:

Veteran                      Active Duty                      Active Reserves                      Other:

With which gender do you most identify?

Female                      Transgender Female                      Non-Conforming  
Male                      Transgender Male                      Self-Identify

With which sexual orientation do you most identify?

Asexual                      Lesbian                      Intersex  
Bisexual                      Queer                      Self-Identify  
Gay                      Questioning                      Straight (heterosexual)  
Prefer not to answer

Ethnicity and Race (check all that apply):

American Indian or Alaska Native                      Native Hawaiian or Other Pacific Islander  
Asian                      Hispanic/Latina/Latino  
Black or African American                      White  
Unknown                      Self-Identify

## Section V: Additional Requirements

### Letter of recommendation:

A letter of recommendation is required to be considered an official representative of an organization or another committee.

### Phone Interview:

A brief phone interview with an OMHSAS Staff Member and Planning Council Co-Chair may be required as part of the selection process.

### Completing this Application:

To be considered for appointment/reappointment, applicants must complete all sections on this application. Contact Cristal Leeper at [cleeper@pa.gov](mailto:cleeper@pa.gov) if you have any questions or concerns, for assistance in completing this form, or to request that the form be provided in a different format or language.

Submit completed membership application to:

**Cristal Leeper, Executive Secretary**  
**Commonwealth of Pennsylvania**  
**DHS-OMHSAS**  
**Office of the Deputy Secretary**  
**Commonwealth Tower 11<sup>th</sup> Floor**  
**P.O. Box 2675**  
**Harrisburg, PA 17105-2675**  
**Email: [cleeper@pa.gov](mailto:cleeper@pa.gov)**  
**Fax: 717-787-5394**

*Thank you for your interest in becoming a member of OMHSAS' Mental Health Planning Council!*

ADMINISTRATIVE USE ONLY  
Date & Initial

Received	DataBase	ListServ	Appt	Term	Letter	Handbook	MHPC
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