*Board Member Application*

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| Name |  | Date |  |
| Address |  |
| City |  | State |  | Zip Code |  |
| Phone |  | Email |  |
| County |  |
| Agency Name |  |
| Agency Address |  |
| City |  | State |  | Zip Code |  |
| Phone |  | Email |  |
| Ethnicity**Please check those that apply** | [ ]  African American[ ]  Asian[ ]  Caucasian | [ ]  Hispanic[ ]  Native American[ ]  Other |

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| Core Principles for representation to the BHAC Membership  |
| * 51% of membership must be a Consumer, Family Member, and Advocacy Organization
* Balance of representation of Mental Health and Substance Abuse Block Grant
* Balance of representation of Prevention, Treatment, and Recovery
* Balance of representation of Gender, Race, and Ethnicity
* Balance of representation across the state; Rural, Urban, and Frontier communities
* Balance of representation for children, adolescents, transitional youth, adults, and older adults
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| Why are you interested in serving on the Montana Behavioral Health Advisory Council (BHAC)? |
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| Identify skills, strengths, and interests that you would bring to BHAC. |
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| BHAC is eager to recruit diverse membership. Please explain how you might contribute to that goal. |
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| List your involvement with behavioral health issues, groups, and/or organizations, including your experience, training and past/present involvement with under-represented communities and groups. |
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| Identify any current work regularly performed for pay as, or for, a provider of behavioral health services. Please indicate the organization, the position you hold, and time of position.  |
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| Please check first column one category that you intend to primarily represent on BHAC. (You may only apply for one category in this column)Second column, please check all other categories you also represent.(As many that apply to you in this column) |
| **For Consumer/Family/Advocacy/In Recovery (51% or more of BHAC membership - Required)** |
|  | Primary(Primarily Representation) | Secondary(Additional Representation by you) |
| **Mental Health** Consumer/Family/In Recovery* Youth
* Adult
* Older Adult
 | [ ] [ ] [ ]  | [ ] [ ] [ ]  |
| **Substance Abuse** Consumer/Family/In Recovery* Youth
* Adult
* Older Adult
 | [ ] [ ] [ ]  | [ ] [ ] [ ]  |
| Family member of an Adult/Older Adult Mental Health  | [ ]  | [ ]  |
| Family member of a Child/Adolescent/Transition YouthMental Health  | [ ]  | [ ]  |
| Family member of an Adult/Older AdultSubstance Abuse  | [ ]  | [ ]  |
| Family member of a Child/Adolescent/Transition YouthSubstance Abuse  | [ ]  | [ ]  |
| Mental Health Advocacy | [ ]  | [ ]  |
| Substance Abuse Advocacy | [ ]  | [ ]  |
| Disabilities Advocacy | [ ]  | [ ]  |
| Veterans Advocacy | [ ]  | [ ]  |
| Community Prevention Advocacy | [ ]  | [ ]  |
| Legal Advocacy | [ ]  | [ ]  |
| Youth Advocacy | [ ]  | [ ]  |
| Other: Please explain | [ ]  | [ ]  |

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| Community |
|  | Primary(Primarily Representation) | Secondary(Additional Representation by you) |
| Family Resource Center | [ ]  | [ ]  |
| Legal/Court | [ ]  | [ ]  |
| Suicide Prevention | [ ]  | [ ]  |
| Centers for Independent Living | [ ]  | [ ]  |
| Sheriff/Police | [ ]  | [ ]  |
| Jail | [ ]  | [ ]  |
| Other: Please explain | [ ]  | [ ]  |

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| For Provider Agency and State Agency (49% or less of the BHAC Membership) |
|  | Primary(Primarily Representation) | Secondary(Additional Representation by you) |
| **Mental Health** Treatment Provider (Managed care ACO, BHO) | [ ]  | [ ]  |
| **Substance Abuse**Treatment Provider (Including Managed Care MSO) | [ ]  | [ ]  |
| Hospital  | [ ]  | [ ]  |
| Private Practice Provider* Mental Health
* Substance Abuse
 | [ ] [ ]  | [ ] [ ]  |
| Recovery Provider  | [ ]  | [ ]  |
| Consumer Provider – Employed over % by provider organization  | [ ]  | [ ]  |
| Crisis Center  | [ ]  | [ ]  |
| Federally Qualified Health Center/Clinic | [ ]  | [ ]  |
| Prevention Provider | [ ]  | [ ]  |
| Residential Treatment Provider* Mental Health
* Substance Abuse
 | [ ] [ ]  | [ ] [ ]  |
| Alternative Care Provider | [ ]  | [ ]  |
| Homeless Service Provider | [ ]  | [ ]  |
| Faith Based Provider | [ ]  | [ ]  |
| LGBTQ Provider | [ ]  | [ ]  |
| Nursing Home/Assisted Living Provider | [ ]  | [ ]  |
| Other: Please Explain | [ ]  | [ ]  |

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| State Agency/Employee |
|  | Primary(Primarily Representation) | Secondary(Additional Representation by you) |
| Behavioral Health | [ ]  | [ ]  |
| Social Services* Child Welfare
* Youth Corrections
* Adult Protective Services
 | [ ] [ ] [ ]  | [ ] [ ] [ ]  |
| Public Health | [ ]  | [ ]  |
| Medicaid | [ ]  | [ ]  |
| Education | [ ]  | [ ]  |
| Veteran/Military Affairs | [ ]  | [ ]  |
| Criminal Justice* Probation
* Prison
 | [ ] [ ]  | [ ] [ ]  |
| Housing | [ ]  | [ ]  |

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| Will you commit to attend scheduled BHAC meetings? |
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| Will you commit to join a Sub-Committee and attend scheduled meetings? |
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I affirm my understanding that by applying for the BHAC committee, does not guarantee being selected for a seat on the BHAC council. Selection to council positions will be recommended by the BHAC membership committee. I further understand that terms on the BHAC council will be rotating and there will be an equal representation by persons, families, providers, and advocates of individuals with mental health and substance use disorders.

[ ]  I agree with the above statement

[ ]  I disagree with the above statement

Please Sign and Date

Signature Date

A completed membership application must be submitted via email, fax or mail to:
Gina Tracy
Gina.tracy@mt.gov