



Oregon Health Authority / Addictions and Mental Health Division
Children Systems Advisory Committee (CSAC)/
Children's Statewide Wraparound Initiative Advisory Committee
Membership Application

Date: _____

Applicant Name: _____

Mailing Address: _____ City: _____ Zip: _____

Telephone: _____ Fax: _____

Email: _____ Cell: _____

1. I am interested and eligible to serve on CSAC as a (if more than one, please indicate your top three choices):

[] Family member of children/youth with a serious emotional disorder who is receiving (or has received) behavioral health services

[] Foster family

[] Family member of children/youth with a substance use disorder who is receiving (or has received) addictions services

[] Young Adult in Transition who is receiving (or has received) behavioral health services

[] Service Provider – Agency Name: _____

[] Addiction Program for adolescents or Young Adults

[] Addiction Program for families

[] Child Welfare (Field)

[] Child Welfare (Policy)

[] Community-based prevention or early intervention program

[] Community Behavioral Health Program or County Behavioral Health

[] Coordinated Care Organization (rural)

- Coordinated Care Organization (urban)
 - County Juvenile Justice
 - Department of Education
 - Local Education or Educational Services Departments
 - Developmental Disabilities/ Intellectual Disability (children's programs)
 - Early Childhood system
 - Federally Recognized Tribe
 - Oregon Children's Alliance
 - Oregon Council of Child and Adolescent Psychiatry
 - Oregon Youth Authority
 - Oregon Family Support Network
 - Oregon Consumer Advisory Council
 - Portland State University/ Research & Training
 - Primary Care
 - Residential Treatment Facility/Program (Acute or Long-Term)
 - Youth M.O.V.E.-Oregon
- Advocate/Support/Community Partner – Agency Name (if applicable): _____
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- Member-at-large – Agency Name (if applicable): _____
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2. Members of the Committee agree to actively participate in at least one subcommittee identified in the yearly CSAC work plan. In 2015, this includes workgroups on addressing issues and systemic barriers to Young Adult Engagement, Suicide Prevention Plan Implementation, Family/Youth Support Workforce and Early Childhood recommendations following application.

3. Please describe why you would like to become a member of CSAC and attach a resume (if applicable).

4. Please share your involvement in local, regional or national planning and/or organizational committees:

5. Please describe how and to whom you would take information from CSAC back to and share:

6. Please share your involvement of services for children or young adults:

7. Please describe the skills, knowledge and strengths that you bring to CSAC.

8. Is there anything else you would like us to know about you?

9. Are you able to attend regularly scheduled meetings in Salem yes no

10. Will you need assistance with translation, accommodation, or signing? yes no

11. CSAC and its subcommittees value and seek to actively promote diverse, inclusive participation by officers and members. As such we request the following demographic information. This information is completely voluntary and will not be shared. Please indicate your age by choosing one of the following categories:

- Under 18
- 18-24
- 25-34
- 35-44

- 45-54
- 55-64
- 65+

Please indicate how you self-identify racially:

- American Indian or Alaska Native
- Asian
- Black, African
- Black, Caribbean
- Black, African-American

- Native Hawaiian or other Pacific Islander
- White
- Decline to Answer
- Unknown

If you identify with more than one race, which one of the following do you consider your primary race identity?

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black, African | <input type="checkbox"/> Decline to Answer |
| <input type="checkbox"/> Black, Caribbean | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Black, African-American | |

Please indicate how you identify ethnically (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Latino/Hispanic | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Not Latino or Hispanic | <input type="checkbox"/> Other (Please specify): |
| <input type="checkbox"/> Decline to Answer | _____ |

If you are an immigrant or refugee, please indicate your country of origin:

If you are an immigrant or refugee, how long has your family lived in the US?

- 1st generation
 2nd generation
 3rd generation or longer

Please indicate your preferred spoken language:

- | | |
|---|--|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Lao/Laotian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Mandarin |
| <input type="checkbox"/> Bosnian | <input type="checkbox"/> Mien |
| <input type="checkbox"/> Burmese | <input type="checkbox"/> Romanian |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Chinese (other) | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> English | <input type="checkbox"/> Somali |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Teochew |
| <input type="checkbox"/> Hmong | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Khmer (Cambodian) | <input type="checkbox"/> Other (Please specify): |
| <input type="checkbox"/> Korean | _____ |

12. Committee members are expected to be present for the majority of all scheduled CSAC meetings, which includes active participation on subcommittees when needed. Your signature on this application indicates your willingness, desire and ability to serve on the Committee, if appointed.

Signed: _____ Date: _____

We thank you for your interest. **Send completed membership application to:**

Jula Krewson
Administrative Specialist
Child & Family Behavioral Health
Oregon Health Authority - OHA
ATTN: CSAC Application
500 Summer St NE, E-86
Salem, OR 97301
jula.krewson@state.or.us

If you have any questions about CSAC, please call Natalie Jacobs at 503-754-4287 or email NATALIE.JACOBS@dhsosha.state.or.us