

Coos County
SYSTEMS OF CARE
COMMUNITY

**Families and Young Adults
Systems of Care Council Application**

If you need this form to be translated please ask

Thank you for completing this application form and for your interest in volunteering with Coos County Systems of Care.

Our Policy:

Systems of Care gives an equal chance for everyone, no matter what race, color, religion, nation of origin (from a different country), sex, sexual preference, age, or disability they have. We can provide special help, called accommodations, for people who need them. If you need any accommodation, like an interpreter or meeting place that works for people in wheelchairs please check box.

Applications are reviewed by the Executive Committee to determine the best committee for each applicant.

YES NO

Contact Information

Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone _____ Other Phone _____

E-Mail Address _____

I am applying as (please check all that apply):

Current OHP Health Plan consumer Current Primary Health Plan consumer

Parent/Guardian of OHP Health Plan or Primary Health Plan consumer

- Parent of Mental Health consumer Previous Wrap Mental Health consumer
- Former OHP Member Parent/Guardian of former OHP member
- Community Member Volunteer

Availability: During which hours are you available for Quarterly Meetings?

- Weekday mornings Weekday afternoons Weekday evenings

Please provide any previous or current personal work or experience in the mental health system for yourself or a youth in your care. (parent/grandparent/foster etc)

Previous Volunteer Experience

Please provide a summary of your previous volunteer experience.

What interests you to be a part of this committee?

Agreement and Signature

I promise that the information in this application is true and complete. I understand that by applying to participate I am agreeing to attend at least quarterly meetings, actively participate in discussions in a positive collaborative manner, and provide honest and direct feedback. Engage all members as equals regardless of title, social/economic or religious standing; for the purpose of enhancing the community and service available throughout Coos County.

Name (printed) _____

Signature _____ Date _____

Please return application by email to coosystemofcare@advancedhealth.com