Application
Office of Children's Mental Health (OCMH)
Collective Impact Parent Partner Application

Return Completed Applications to
Joann Stephens, OCMH
1 West Wilson, Rm. 656
Madison, WI 53703
By FAX – 608-267-9392

Name: _____

Address: _____

City: _____ State: _____ Zip _____

Email Address: _____ Phone: _____

I self-identify as a parent or caregiver of a child or young person with a mental health, substance use or trauma related issue. Yes ☐ No ☐

I self-identify as a person with a mental health, substance use or trauma related issue.
Yes ☐ No ☐

I have skill and experience successfully navigating multiple service systems such as schools, public mental health, child welfare, juvenile justice, substance use services, etc.
Yes ☐ No ☐

I have knowledge of the following principles of practice:

person-centered	Yes ☐	No ☐	I want more info ☐
recovery-oriented	Yes ☐	No ☐	I want more info ☐
family-driven	Yes ☐	No ☐	I want more info ☐
youth-guided	Yes ☐	No ☐	I want more info ☐
trauma-informed	Yes ☐	No ☐	I want more info ☐
culturally-competent	Yes ☐	No ☐	I want more info ☐

I have an understanding of children/youth systems of care such as Wraparound, Coordinated Services Teams (CST), and Comprehensive Community Services (CCS).
Yes ☐ No ☐ I want more info ☐

I have skill and experience participating in macro-level systems' change (ie: local community, county, or state, etc).
Yes ☐ No ☐

Are you affiliated with an organization or agency? (ie: WI Family Ties, NAMI, CESA, etc?)
If so, please list:

Please describe a triumphant moment in your past advocacy efforts or system engagement:

Please describe a low moment in your past advocacy efforts or system engagement:

I would like to participate as an OCMH Parent Partner for the following reasons:

I have the following **skills**, **strengths** and **experiences** in using my lived experience in systems change efforts. Be as specific as possible.

Once trained to participate in the OCMH Collective Impact process I am expected to be available to attend monthly meetings over the course of one year. Re-evaluation for goodness of fit will take place every 6 months. Please initial below the following:

☐ I have transportation available.

☐ I agree if chosen that I will be an active participant in ongoing meetings and communicate with the coordinator as needed, via email and / or phone contact.

☐ I am interested in learning about co-chairing an OCMH Collective Impact workgroup (optional)

I agree to these guidelines. Please consider my application to be an OCMH Collective Impact Partner (CIP).

Signature (typing your name serves as signature)

Date

Please provide two references that attest to the skills, strengths, and experiences identified on this application.

NAME/TITLE:

ADDRESS:

TELEPHONE:

EMAIL:

NAME/TITLE:

ADDRESS:

TELEPHONE:

EMAIL: