



Wisconsin Office of Children’s Mental Health
Collective Impact Parent Partner Application



Please answer the questions below. There are no wrong answers.
Your application will remain private and confidential.

Name: _____ City: _____

Email: _____ Phone: _____

I am the parent or primary caregiver of a child who has experience with...

Mental Health • Social-Emotional Needs • Substance Use • Trauma

Yes No

I have navigated multiple systems to care for myself or my family. Examples include...

Schools • Mental Health Services • Child Welfare • Youth Justice • Substance Use Services •
Counseling • Birth to Three • Crisis Intervention • Mental Health Hospitalization

Yes No

I have the time and energy to attend meetings for 2-8 hours each month.

Yes No

I focus on the strengths of others and can find the positive in a tough situation.

Yes No

I think *big picture*- I see how my experiences could benefit others.

Yes No

On a scale of 1 to 5, my level of interest in learning and developing as a leader is...

(Circle a number below)

Not At All Interested 1 2 3 4 5 Very Interested



Please describe your *skills, strengths, and experiences* related to improving the children’s mental health system:

If you could make one change in the current children’s mental health system, what would that change be? How might you work with others to make that change?

I would like to participate as a Collective Impact Partner for the following reasons:

Please provide two people who can tell me about your skills, strengths, and experiences:

Name of Reference #1: _____

Their Email: _____ Their Phone: _____

Name of Reference #2: _____

Their Email: _____ Their Phone: _____

Please consider my application to be a Collective Impact Partner.

Signature _____
Date