Association for Children’s Mental Health

Statewide Youth Advisory Committee



Application Form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Your Contact Information** | | | |  |
| Name: |  | | |  |
| Age: |  | Date of Birth: |  |  |
| Street Address: |  | | |  |
| City: |  | Zip Code: |  |  |
| County: |  | | |  |
| Home Phone: |  | | |  |
| Cell Phone: |  | | |  |
| Email Address: |  | | |  |
|  |  | | |  |

**Diversity Information**

The following diversity questions are **VOLUNTARY**; however, please note that the purpose of these questions is to reflect ACMH’s commitment to diversity.

Check One: Male Female Other

Check One: American Indian/Alaskan Native Black/African American  
Hispanic/Latino Asian/Pacific  
White Other

|  |
| --- |
| The committee should be represented by youth with wide ranges of backgrounds, experiences and perspectives. Please let us know anything about your background, experience, perspective, and any unique attributes or assets that you believe will help you bring a variety of knowledge and understanding of different topics to the group. |
|  |

**Short Answer Questions**

Please answer the following questions.

|  |
| --- |
| Why are you interested in joining the ACMH Statewide Youth Advisory Committee? |
|  |

|  |
| --- |
| Describe the qualities, traits, and skills that a leader would demonstrate. |
|  |

|  |
| --- |
| The purpose of the council is to increase youth voice and create positive changes in the mental health community. Describe a problem or issue facing youth with mental health challenges. How might youth leaders help? |
|  |

|  |  |  |
| --- | --- | --- |
| **Adult Sponsor Information** | |  |
| Please indicate the name of a person who you have identified as your adult sponsor.  Please attach a letter of reference from your sponsor to this form. | |  |
| Name |  |  |
| Phone Number |  |  |
| Email Address |  |  |
|  |  |  |

**Agreement and Signature**

If selected I understand that:

* I will work with ACMH to identify an adult sponsor to support me in Committee Activities.
* Meetings and events may be photographed, videotaped, and/or tape recorded.
* I am to participate in all Committee activities.
* I am making a commitment to be a leader in my community.

I have reviewed the Committee description, understand the expectation of Committee members, and completed the application as accurately as possible.

|  |  |
| --- | --- |
| Name (printed): |  |
| Signature: |  |
| Date: |  |

**What to Do Now**

You may email this application to Sara Reynolds at [SReynolds@acmh-mi.org](mailto:SReynolds@acmh-mi.org) or send it in the mail to:

Sara Reynolds

Association for Children’s Mental Health

6017 W St. Joe Hwy, Suite 200

Lansing, MI 48917

Please contact Sara Reynolds with any questions at  
517-643-3544 or SReynolds@acmh-mi.org