Bexar CARES Governance Council
Organization Membership Application

Type of membership requested: ☐ Council Member ☐ Stakeholder
(Please complete the appropriate section below. Attach additional pages as necessary.)
If you are interested in working to create a System of Care in Bexar County, please fill out the information below and submit it to F. Leanne Lindsey: flindsey@chcsbc.org

Application Date:_____

Organization name: _____

Chief Executive's Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ Zip: _____

Organization's mission:_____

_____

Type of organization: ___ Non-profit organization ___For-profit organization ___ Child Serving System

Do you provide services related to mental health? _____ If so, please list or attach list:

_____

Primary Organizational Contact (this person will be designated as a participating member of the council and will be authorized to vote on behalf of the organization):

Name: _____

Title: _____ E-Mail: _____

Phone: _____ Fax: _____

Please list your educational background: _____

Licenses/credentials/certifications: _____

Web-Site Address: _____

In just a few sentences tell us about your experiences, if any, in advocacy for children's mental health.

What experience, if any, have you had working in a large task group?

What do you think that you would need from us to support you in doing this work?

Tell us about your reasons for wanting to get involved with Bexar CARES.

Do you have family members who are affected by mental illness?
I am a: Consumer ____ Caregiver: ____ MH Professional: ___Other: _____