



CALIFORNIA NETWORK of MENTAL HEALTH CLIENTS

2012 - 19th Street, Suite 100, Sacramento, California 95818

(916) 443-3232 ■ (800) 626-7447 ■ Fax: (916) 443-4089 ■ info@californiaclients.org ■ www.californiaclients.org

Client Membership Application

- New Member
 Current Member (Update Information)

PLEASE PRINT CLEARLY

Name: _____ Date of Birth: ___/___/___

Address: _____

City _____ Zip _____ County _____

Phone () _____ E-mail _____

_____ Please initial here if the Network office can give your phone/address to members who want to network in your area. (If you leave this blank, we will not give out *your name, address, or phone numbers without your specific permission*)

_____ I am currently, or have been in the past, a mental health client.

Please check one of the following options:

- \$5.00 membership for one year.
- Scholarship Donation: I will donate \$_____ to help other clients.
- At this times I not able to afford \$5.00, but am willing to donate time and skills as I am able: these are skills I have to offer: _____

Cultural and Ethnic Identity (*This section is optional: voluntary self-identification*)

Please check all that apply:

RACE or ETHNICITY

- 1__ American Indian or Alaskan Native
 2__ Hispanic/Latino
 3__ Black /African-American
 4__ European Descendant
 5__ Asian/ Pacific Islander
 6__ Other (Specify): _____

CULTURAL

- 1__ Veteran
 2__ Homeless or formerly homeless
 3__ Transition Age Youth (18 – 25 years old)
 4__ Older Adult
 5__ LGBTQ
 6__ Physical Disability
 7__ Other (Specify): _____

Please Return to Address Noted on Reverse Side

OFFICE USE ONLY		
Region: _____	Paid: \$_____	Date: ___/___/___
Staff: _____		