LOS ANGELES COUNTY DMH & DPH-SAPC

BHSA Community Planning Team

AGENDA	
DATE: Friday, March 28, 2025 | 9:30 – 12:30 PM **MEETING LINK**: Click **Join the meeting now** **MEETING ID**: 221 101 411 058 | **PASSCODE**: Cq94iB3k	**DIAL IN BY PHONE #:** +1 323-776-6996,,255407060# **PHONE CONF ID**: 255 407 060#

OBJECTIVE	1. Launch the Behavioral Health Service Act Community Program Planning (BHSA CPP) Process by reviewing core BHSA content and process and responding to questions.
TIME	**ITEMS**
9:30 (15 min)	**I. SESSION OPENING** A. Key Announcements B. Land and Labor Acknowledgements C. Agenda Review
9:45 (15 min)	**II. WELCOME** A. Dr. Lisa H. Wong, Psy.D., Director, Los Angeles County Department of Mental Health B. Dr. Gary Tsai, MD, Director; Substance Abuse Prevention and Control Bureau (SAPC), Los Angeles County Department of Public Health
10:00 (60 min)	**III. REVIEW CORE BHSA CONTENT: BEHAVIORAL HEALTH TRANSFORMATION, SCOPE, CONTINUUMS, AND INTEGRATED PLAN** A. Presentation (25) 1. Kalene Gilbert, LCSW, Mental Health Program Manager IV, MHSA Administration & Oversight Division, LACDMH 2. Michelle Gibson, Deputy Director, LACDPH-SAPC B. Dialogue (35 min)
11:00	**IV. BREAK**
11:10 (65 min)	**V. REVIEW KEY BHSA PROCESS: STAKEHOLDER GROUPS, ENGAGEMENT AGREEEMENTS, & BHSA CPP ROADMAP** A. Presentation (25 min) 1. Kalene Gilbert, LCSW, Mental Health Program Manager IV, MHSA Administration & Oversight Division, LACDMH 2. Katherine Li, Staff Analyst, LACDPH-SAPC B. Dialogue (40 min)
12:25 (5 min)	**VI. CLOSING** A. Next Steps B. Meeting Evaluation
12:30	**VII. ADJOURN**

BHSA BACKGROUND[1]

PROPOSITION 1

Californians voted to pass Proposition 1 to modernize the behavioral health delivery system, improve accountability and increase transparency, and expand the capacity of behavioral health care facilities for Californians. Proposition 1 includes up to $6.4 billion in bonds to build new supportive housing and community-based treatment settings. DHCS is enacting changes resulting from Proposition 1 through the Behavioral Health Transformation project. The two legislative bills that created the language in Proposition 1 are:

- Behavioral Health Services Act SB 326
- Behavioral Health Bond Act AB 531

BEHAVIORAL HEALTH TRANSFORMATION (Page 5)

In late February 2025, The Department of Health Care Services (DHCS) published the Behavioral Health Services Act County Policy Manual that provides counties with guidance to implement Behavioral Health Transformation, or BHT. DHCS envisions BHSA as part of a larger BHT initiative that includes a 'package of behavioral health policy reforms enacted by California voters through Proposition 1 (2024) and will take effect according to statutory timelines.'

BHT'S PRIMARY GOALS (Page 6)

The primary goals of BHT are to improve access to care, increase accountability and transparency for publicly funded, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California.

BHT BUILDS UPON AND ALIGNS MAJOR BH INITIATIVES IN CA (Page 6)

BHT builds upon and aligns with other major behavioral health initiatives in California including the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) initiative, the Children and Youth Behavioral Health Initiative (CYBHI), Medi-Cal Mobile Crisis services, the Behavioral Health Bridge Housing program, the Community Assistance, Recovery, and Empowerment (CARE) Act, Lanterman-Petris-Short Conservatorship reforms, 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP).

FACTORS IMPACTING BEHAVIORAL HEALTH (Pages 6-7)

California continues to face behavioral health challenges impacted by many factors, including but not limited to the lack of affordable housing and increasing homelessness, the behavioral health workforce

[1] Department of Health Care Services. Behavioral Health Services Act County Policy Manual (February 2025/FINAL) https://www.dhcs.ca.gov/BHT/Documents/Behavioral-Health-Services-Act-County-Policy-Manual.pdf

shortage, a youth mental health crisis, an older adult mental health crisis, and a shortage of culturally responsive and diverse care. Many of these challenges make it difficult for individuals to navigate California's behavioral health care delivery systems and access services at the right time and in the right place. For example, 2022 survey research suggests that 23.5 percent of adult Californians across all payers living with a mental illness reported they did not receive the treatment they needed.

PROPOSITION 1 INCLUDES BH INFRASTRUCTURE BOND (Page 7)

Proposition 1 includes the Behavioral Health Infrastructure Bond Act of 2023. This bond authorizes $6.38 billion to build new behavioral health treatment beds and supportive housing units to help serve more than 100,000 people annually. This investment creates new, dedicated housing for people experiencing or at risk of homelessness who have behavioral health needs, with a dedicated investment to serve veterans.

BEHAVIORAL HEALTH SERVICES ACT: STRUCTURAL REFORM (Pages 8-10)

The Behavioral Health Services Act (BHSA) is the first major structural reform of the Mental Health Services Act (MHSA) since it was passed in 2004. Key opportunities for transformational changes within BHSA include:

- Reaching and Serving High Need Priority Populations.
- Increasing Access to Substance Use Disorder Services, Housing Interventions, and Evidence-Based and Community-Defined Practices, and Building the Behavioral Health Workforce.
- Focusing on Outcomes, Transparency, Accountability, and Equity

BHSA ELIGIBLE POPULATIONS (Pages 11-12)

Eligible populations are those that may receive services funded by the Behavioral Health Services Act (BHSA) and include children and youth, adults, and older adults who meet BHSA eligibility criteria. Eligibility criteria for BHSA services are aligned with Medi-Cal specialty mental health services (SMHS) access criteria and include individuals with substance use disorders as described below. However, it is important to note that BHSA eligible populations are not required to be enrolled in the Medi-Cal program.

Eligible children and youth means persons who are 25 years of age or under who meet either of the following:

- Meet SMHS access criteria specified in subdivision (d) of W&I Code section 14184.402 and implemented in SMHS guidance11 (includes individuals 21-25 years of age who meet this criteria) OR
- Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.

Eligible adults and older adults means persons who are 26 years of age or older who meet either of the following:

- Meet SMHS access criteria specified in W&I Code section 14184.402, subdivision (c) and implemented in DHCS guidance13 (only applies to individuals 26 years of age and older) OR
- Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.

PRIORITY POPULATIONS (Pages 12-13)

BHSA also requires counties to prioritize BHSA services for the populations listed below:

Eligible children and youth who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness
- Are in, or at risk of being in, the juvenile justice system
- Are reentering the community from a youth correctional facility
- Are in the child welfare system pursuant to W&I Code sections 300, 601, or 602
- Are at risk of institutionalization

Eligible adults and older adults who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness
- Are in, or at risk of being in, the justice system
- Are reentering the community from state prison or county jail
- Are at risk of conservatorship
- Are at risk of institutionalization

For additional information about criteria or priority populations for Full Service Partnerships and Housing Interventions, including the definition for "chronically homeless, please refer to the corresponding sections within this manual.

BEHAVIORAL HEALTH

A condition of well-being for persons with a…

CAPTURING BH FUNDING

BHSA requires counties to submit three-year Integrated Plans for Behavioral Health Services and Outcomes (IP) that outline planned county activities and projected expenditures for all county behavioral health services funded under the following behavioral health funding streams:

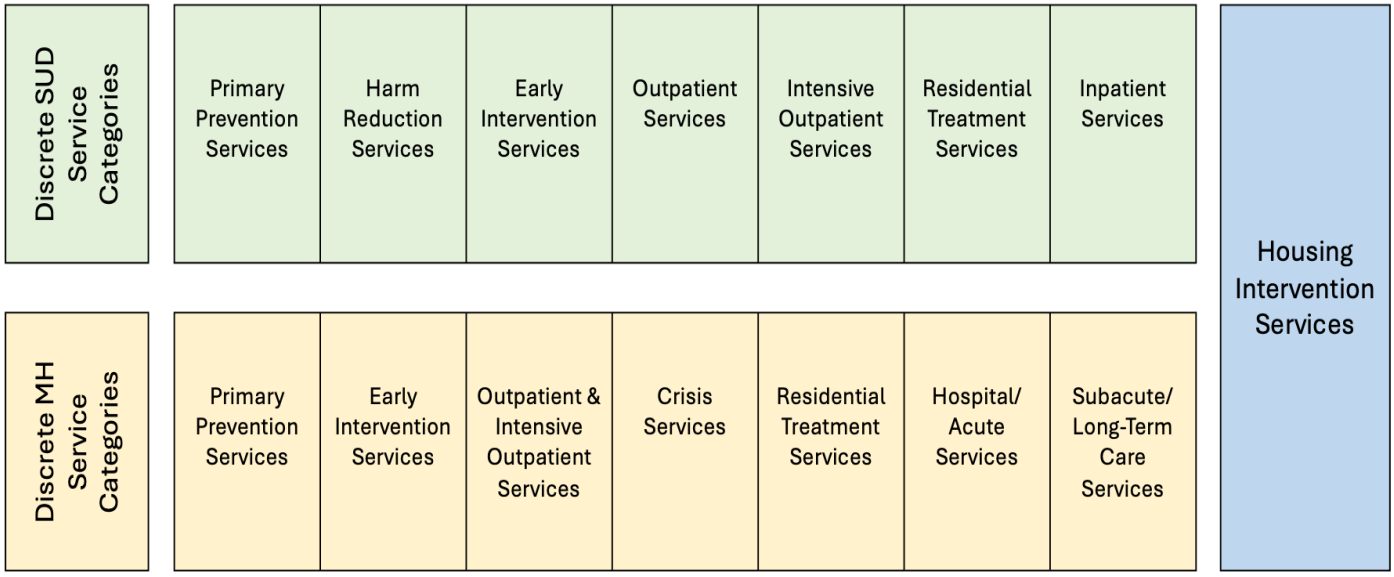
- Bronzan-McCorquodale Act (1991 and 2011 Realignment)

- Medi-cal Behavioral Health Programs, Including: Specialty Mental Health Services, Drug Medi-cal, Drug Medi-cal Organized Delivery System
- Federal Block Grants
- Opioid Settlement Funding
- BHSA Funds

COUNTY BEHAVIORAL HEALTH CONTINUUM OF SERVICES CAPACITY

The Integrated Plan is also required to include a demonstration of how the county will utilize various funds for behavioral health services to deliver high-quality, culturally responsive, and timely care ***along the continuum of services*** in the least restrictive setting from prevention to wellness in schools and other setting to community-based outpatient care, residential care, crisis care, acute care, and housing services and supports.

BEHAVIORAL HEALTH CONTINUUM



NEW BHSA REPORTING REQUIREMENTS

MHSA REQUIREMENTS

- Three-year Program and Expenditure Plans
- Annual Updates
- Annual Revenue and Expenditures Report (ARER)

BHSA REQUIREMENTS

- Three-year Integrated Plans
- Annual Updates
- Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)

THREE YEAR COUNTY INTEGRATED PLAN (IP)

PURPOSE	Prospective plan and budget for all county Behavioral Health services.
GOAL	Standardize data collection and reporting to increase transparency, promote stakeholder engagement, and improve local outcomes. • Collect local and aggregate information on all behavioral health services statewide. • Increase transparency and accountability in county reporting. • Conduct robust data analysis across counties, services, and funding streams and identify gaps in service delivery.
FREQUENCY	Developed every 3 years.
TIMING	First IP due June 30, 2026.

KEY BHSA IP REQUIREMENTS

TOPICS	DETAILS
Stakeholder Engagement	Stakeholder involvement on: • Mental health and substance use disorder policy • Program planning and implementation • Monitoring • County workforce • Quality Improvement • Health equity • Evaluation • Budget allocation
Public Comment and Hearing	30-day comment, public hearing, and annual report on recommendations not included in the plan
County Demographics & Behavioral Health Needs	County demographics, unmet BH needs and disparities, collaboration with MCPs and local health jurisdiction, plans to improve BH outcomes for specified populations

KEY BHSA IP REQUIREMENTS

TOPIC	DETAILS
Plan Goals & Performance Reporting	County goals and objectives and description of alignment with statewide and local goals, outcome measures, and performance outcome measures.
Service & Expenditure Plan	Description of all planned local, state, and federally funded BH services, including Continuum of Care capacity and budget.
Workforce / Personnel	Strategy to ensure BH workforce is robust, well-supported, and culturally and linguistically concordant with populations served.
Prudent Reserve	Prudent reserve for BHSA-funded services.
Local Certification	Compliance with all pertinent policies and fiscal accountability requirements.

BHSA CPP PROCESS

PHASE 1: OUTREACH & INPUT	PHASE 2: RECOMMENDATIONS	PHASE 3: CONSENSUS
April | May | June	July | August | September	October | November | December
FOCUS: Foundation Building + Outreach & Input	**FOCUS:** Workgroup Recommendations	**FOCUS:** Stakeholder Agreement

FOUNDATION BUILDING

BHSA CPT

- Affirms Shared Vision.
- Charters Workgroups focused on Integrated Plan topics.
- Analyzes MH & SUD Systems, Data & Disparities.

OUTREACH & INPUT

Stakeholder Groups

- Forums
- Focus Groups
- Interviews

WORKGROUPS

- Workgroups are open to the public for full participation.
- Workgroups conduct analysis focused on specific topics and produce recommendations to the BHSA CPT for the Integrated Plan, addressing disparities.

BHSA CPT

- Reviews Workgroup recommendations for the Integrated Plan.
- Builds consensus on key recommendations for the Integrated Plan.

BHSA CPP PROCESS

PHASE 4: INTEGRATED PLAN APPROVAL					
DRAFT INTEGRATED PLAN	**POST** INTEGRATED PLAN	**HOLD** PUBLIC HEARING	**APPROVE** INTEGRATED PLAN		
JANUARY	FEBRUARY	APRIL	MAY	MAY/JUNE	JUNE
• Department Directors review. • Write draft Integrated Plan. • LA County Counsel vets Integrated Plan. • Summarize Integrated Plan in plain language. • Translate Integrated Plan.	• 30-Day Public Posting • Collect and summarize feedback from stakeholder groups.	• Los Angeles County Behavioral Health Commission holds a Public Hearing on the Integrated Plan and proposes changes (if any).	Los Angeles County Board of Supervisors reviews Integrated Plan, makes changes (if any), and votes to approve.	California Department of Health Care Services (DHCS) - Submission and review.	Commission for Behavioral Health (CBH) - Submission and review.

BHSA CPT STAKEHOLDER GROUPS & MEMBERS

PROPOSAL: Establish a BHSA Community Planning Team based on the following principles:

1. A critical mass of 160 members representing the social and cultural diversity of Los Angeles County across three stakeholder categories:
    a. People with Lived Experience with Mental Health Needs (MH), Substance Use Needs (SUD), or Both.
    b. Service Providers representing MH, SUD, or both.
    c. Systems Representatives representing MH, SUD, or other areas.
2. Equal representation for the fields of MH and SUD.
3. A majority of representatives (82) formally represent People with Lived Experience in MH and SUD.

CATEGORIES	MH	SUD	Both	Sub-Totals
A. People with Lived Experience	41	41	N/A	82
B. Service Providers	12	12	20	44
C. Systems Representatives	0	0	34	34
Sub-Totals	53	53	54	160

CATEGORY A: PEOPLE WITH LIVED EXPERIENCE (82)

MH Stakeholder Groups (10) & Number of Representatives (41)	SUD Stakeholder Groups (8) & Number of Representatives (41)
1. Cultural Competency Committee (2) 2. Eligible Adult (1) 3. Eligible Older Adult (1) 4. Faith-Based Advocacy Council (2) 5. Families and/or caregivers of eligible children and youth, eligible adults, and eligible older adults (1) 6. Homelessness/People Experiencing Homelessness (1) 7. SALT Co-Chairs (16) 8. UsCC Co-Chairs (14) 9. Veterans (1) 10. Youth Mental Health Council (2)	1. Cultural Competency Committee (2) 2. Eligible Adult (1) 3. Eligible Older Adult (1) 4. Families and/or caregivers of eligible children and youth, eligible adults, and eligible older adults (1) 5. Homelessness/People Experiencing Homelessness (1) 6. People with lived experience with substance use (inclusive of family, and/or partner, and/or frontline worker representation) (32) 7. Youth Substance Use Peer Council (25 & Under) (2) 8. Veterans (1)

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CATEGORY B: SERVICE PROVIDERS (48)

MH Stakeholder Groups (8) & Number of Representatives (12)	SUD Stakeholder Groups (8) & Number of Representatives (12)
1. Association of Community Human Service Agencies (ACHSA) (1) 2. Community Health Workers/*Promotoras* (2) 3. Housing Providers (1) 4. Housing System (1) 5. National Alliance for Mental Illness (1) 6. Peer Advisory Council (2) 7. Peer Support Specialists (2) 8. Service Providers (Non-ACHSA) (2)	1. California Association of Alcohol and Drug Program Executives (CAADPE) (1) 2. California Opioid Maintenance Providers (COMP) (1) 3. Housing Providers (1) 4. Housing System (1) 5. Substance Use Counselors (2) 6. Substance Use Harm Reduction (2) 7. Substance Use Prevention (2) 8. Substance Use Treatment (2)
Both MH+SUD Stakeholder Groups (5) and Number of Representatives (20)	
1. Community Based Organizations Working with Youth from Historically Marginalized Communities, and/or Underserved Racially and Ethnically Diverse Communities, and/or LGBTQ+ Communities, and/or Victims/Survivors of Domestic Violence and Sexual Abuse (4) 2. First 5 Los Angeles/Early Childhood Organizations (1) 3. Health Neighborhoods (8) 4. Labor representative Organizations/Unions (4) 5. Los Angeles County Behavioral Health Commission (2) 6. Veterans Organization (1)	

CATEGORY C: SYSTEMS REPRESENTATIVES (34)

County (17)	CEO: Executive Office (1); Anti-Racism, Diversity & Inclusion (1) Departments: Aging and Disability (1); Children and Family Services (1); Firefighters/First Responders (1); Health Services (1); Justice, Care & Opportunities Department (1); Military and Veterans Affairs (1); Parks and Recreation(1); Libraries (1); Probation/Juvenile Justice (1); Psychiatric Hospitals(1); Public Defender(1); Public Health – Health Promotion (1); Public Social Services(1); Sheriff's Department(1); Youth Development (1).
Education (5)	California State University (1); Los Angeles County Office of Education (1); Los Angeles Community College District (1); Los Angeles Unified School District (1); University of California (1).
Local Governments & Quasi-Governmental Agencies (12)	Local Health Jurisdictions: Long Beach (1) and Pasadena (1) Most Populous Cities: Glendale (1); Lancaster (1); Long Beach (already included); Los Angeles (1); Santa Clarita (1) Quasi-Governments: Disability Insurers (1); Health Care Organizations/Hospitals (1); Los Angeles Homeless Services Authority (1); Managed Care Plans (1); Regional Centers (1); Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes (1).

ENGAGEMENT AGREEMENTS

COLLABORATIVE PRACTICES

The COLLABORATIVE PRACTICES cover four areas that guide the relationship between DMH and DPH and the BHSA CPT members.

AREAS	PRACTICES
Meaningful Engagement	Engage community stakeholders in a meaningful way that includes the following practices: 1. Establish a clear purpose, objectives, and phases for the overall community planning process. 2. Reach out to a broad range of community and systems stakeholders to participate in the community planning process. 3. Involve stakeholders in generating data, analyzing information, and issuing recommendations versus simply asking them to endorse already made decisions. 4. Provide enough information on a given proposal in order to issue an informed recommendation (e.g., population served, geographical area, funding amount, budget, etc.). 5. Give participants enough time to review materials in advance of meetings. 6. Make progress from meeting to meeting towards the stated objectives within a reasonable timeline, so that participants are not rushed into making recommendations. 7. Ensure respect and decorum during the meetings, free of personal attacks; and 8. Loop back with community stakeholder groups to communicate a recommendation, decision, and/or plan.
Efficient Communication & Coordination	Meaningful engagement depends heavily on efficient communication and coordination that includes: 1. Enough advance notice of meeting dates and times. 2. Sufficient and relevant information in plain language. 3. Translated materials at the same time as English materials. 4. Information provided on a timely basis at least one week before the meetings. 5. Avoid setting meetings that structurally conflict with existing community stakeholder meetings that are known (e.g., SALT & UsCC meetings, etc.). 6. A centralized email address where a staff person can answer questions. 7. A centralized and updated list of participants to ensure everyone is receiving information.
Accessible Meetings	Ensure the following conditions at all meetings to eliminate barriers to full participation: 1. Offer financial support to consumers/clients to offset costs of participation (e.g., transportation, etc.).

AREAS	PRACTICES
	2. Use different ways to engage each other in meetings, e.g., different locations and times, and modes of access (e.g., in-person, online, etc.). 3. Offer interpretation (i.e., ASL, Spanish, Korean, and other threshold languages) and CART services at every meeting. 4. Provide materials in the appropriate font size for those who request it. 5. Ensure contrast between text and background (avoid light text on light background, or dark text on dark background). 6. Embed titles/descriptions when using pictures (including graphs and diagrams). 7. Provide food if meetings are more than two hours.

COMMUNICATION EXPECTATIONS

The COMMUNICATION EXPECTATIONS guide the interaction and communication among everyone involved in the CPT meetings.

AREAS	PRACTICES
Be Present	Be on time and do your best to participate and engage each other in the spirit of conversation and learning.
Speak From Your Own Experience	Sharing views that are rooted in your experiences helps us build community. It helps all of us find areas where we can relate and connect with each other.
Practice Confidentiality	The practice of respecting and protecting sensitive information that people share with you helps to builds trust.
Step Up, Step Back	To 'step up' means to being willing to share your thoughts and experiences with others so that your voice is part of the conversation. To 'step back' means being aware and mindful that others also need time to speak, and that some people take a little longer to compose their thoughts.
Seek To Understand, Then Be Understood	Ask questions to understand someone's view before expressing your view. This helps everyone feel heard and prevent misunderstandings.

BHSA COMMUNITY PLANNING PROCESS (BHSA CPP ROADMAP)

PHASE	MONTH	MILESTONES
Preparation & Frameworks	Jan	• Generate information on community stakeholders' understanding of Behavioral Health and Integrated Behavioral Health System using a survey. • Share proposed frameworks for BHSA Community Planning Team (CPT) Stakeholder Groups and Engagement Agreements, obtain feedback, and modify frameworks, as appropriate.
	Feb	• Capture current understanding of Behavioral Health and integrated care from the perspective of community stakeholders. • Share scope of Behavioral Health within the context of BHSA, including a continuum that covers SUD and MH service categories. • Discuss the Integrated Plan requirement in relation to the continuums. • Provide an overview of Community Program Planning (CPP) Roadmap.
	Mar	• Finalize stakeholder groups, engagement agreements, and CPP. • Review consensus building and decision-making process. • Finalize BHSA Member Information Form to document the social-cultural diversity of CPT members. • Conduct BHSA kickoff session on Friday, March 28th.
1 Foundation Building and Outreach & Input	Apr	• Provide a more in-depth review of the MH and SUD continuums. • Provide BHSA 101 presentation to community stakeholders (including Behavioral Health, Continuums, Integrated Plan, etc.).
	May	• Review unmet needs and service gaps. • Obtain information from community stakeholder groups on unmet needs and service gaps pertaining to MH and SUD.
	Jun	• Review unmet needs and service gaps.
2 Recom-mendations	Jul	• Workgroups discuss and prioritize needs within Workgroup.
	Aug	• Workgroups develop recommendations to address priorities.
	Sep	• Workgroups agree on recommendations for CPT, and articulate areas of divergence.
3 Consensus Building	Oct	• CPT members review Workgroup recommendations and begin building consensus on recommendations.
	Nov	• CPT members build consensus on Workgroup recommendations.
	Dec	• CPT members agree on recommendations and articulate areas of divergence.
4 Integrated Plan Approval	January	• Department Directors review. • Write draft Integrated Plan. • LA County Counsel vets Integrated Plan. • Summarize Integrated Plan in plain language. • Translate the Integrated Plan.
	Feb	• 30-Day Public Posting

PHASE	MONTH	MILESTONES
	Mar	Collect and summarize feedback from stakeholder groups.
	Apr	Los Angeles County Behavioral Health Commission holds a Public Hearing on the Integrated Plan and proposes changes (if any).
	May	Los Angeles County Board of Supervisors reviews Integrated Plan, makes changes (if any), and votes to approve.
	Jun	California Department of Health Care Services reviews Los Angeles County's BHSA Integrated Plan. Commission for Behavioral Health reviews Los Angeles County's BHSA Integrated Plan.
Implementation	Jul	Implementation of BHSA Integrated Plan begins.

LOS ANGELES COUNTY DMH & DPH-SAPC
BHSA Community Planning Team

BHSA CPT MEMBER INFORMATION FORM

We want the BHSA CPT members to mirror the social and cultural diversity of Los Angeles County. The Member Information Form (MIF) is a tool to gather the BHSA CPT members' diversity. Providing information is entirely voluntary. You can choose to not to provide any or all information requested. Information will be kept confidentially with designated staff members and will be shared publicly only in aggregate terms (i.e., without personally identifying information).

SECTION 1: CONTACT INFORMATION

First Name	Last Name	Pronouns	Mobile Phone	
Home Phone	Office Phone	Email Address	Work Address	
Mobile Number Use:	For your mobile phone number, can we send you text messages (i.e., meeting reminders, urgent updates, others)?			Yes No

SECTION 2: LIVED EXPERIENCE

Which Lived Experience(s) do represent as your primary one on the BHSA Community Planning Team (CPT)?

☐ Consumer of Mental Health (MH) Services (past or present)	☐ Consumer of Substance Use Disorder (SUD) Services (past or present)	☐ Consumer of Co-Occurring (COD) Services (past or present)
☐ Caregiver - MH	☐ Caregiver - SUD	☐ Caregiver – COD
☐ Family Member - MH	☐ Family Member - SUD	☐ Family Member - COD
☐ Other:	☐ Other:	☐ Other:

Please select all other Lived Experience(s) you bring to the Community Planning Team:

Domestic Violence	Homeless/Houseless	Veteran	Other

SECTION 3: DIVERSITY

AGE

Age Range

0-15	16-25	26-59	60+

DISABILITY[2]

Do you have a disability?

None	Yes	Prefer not to answer

If yes, select all that apply to you:

Type	Includes

[2] Adapted from Yale University. *Types of Disabilities*. Downloaded on March 1, 2025. https://usability.yale.edu/web-accessibility/articles/types-disabilities

☐ Auditory	Hard of Hearing; Deafness
☐ Cognitive, Learning, Neurological	Attention Deficit Hyperactivity Disorder; Autism Spectrum Disorder; Memory Impairments; Perceptual Disabilities (also 'learning disabilities') Seizure disorders. (Can also include mental health disabilities causing difficulty focusing, processing, and understanding information.)
☐ Physical	Amputation; Arthritis; Paralysis; Repetitive Stress Injury
☐ Speech	Muteness; Dysarthia; Stuttering
☐ Visual	Color blindness; Low Vision; Blindness

GEOGRAPHY

If you represent a Service Provider or Community Based Organization, select the Service Area (or Service Areas) where you deliver services in Los Angeles County.

All	SA1	SA2	SA3	SA4	SA5	SA6	SA7	SA8

LANGUAGE

Please select your primary language:

Armenian	English	Mandarin	Spanish	Other
Cambodian	Farsi	Other Chinese	Tagalog	
Cantonese	Korean	Russian	Vietnamese	

Not including your primary language, please select the language(s) you are fluent in:

Armenian	English	Mandarin	Spanish	Other
Cambodian	Farsi	Other Chinese	Tagalog	
Cantonese	Korean	Russian	Vietnamese	

RACE & ETHNICITY[3]

Select your 'race' and ethnicity. If multiple 'races', check all that apply.

Race	Ethnicity/Ancestral Heritage (Examples)	Your Ethnicity
☐ White	English, French, Dutch, German, Irish, Italian, Polish, Scottish, Norwegian, etc.	
☐ Hispanic or Latino	Colombian, Cuban, Dominican, Guatemalan, Mexican, Mexican American, Puerto Rican, Salvadoran, etc.	
☐ Black or African American	African American, Barbadian, Ethiopian, Ghanian, Haitian, Jamaican, Nigerian, Somali, South African, etc.	
☐ Asian	Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Pakistani, Vietnamese, etc.	
☐ American Indian or Alaska Native	Blackfeet Tribe, Native Village of Barrow Inupiat Tribal Government, Navajo Nation, Tlingit, etc.	

[3]Adapted from the US Census Bureau. *Updates to Race/Ethnicity Standards for Our Nation*. Downloaded on March 1, 2025. https://www.census.gov/about/our-research/race-ethnicity/standards-updates.html#:~:text=The%20key%20revisions%20in%20the,as%20a%20new%20minimum%20category.

☐ Middle Eastern or North African	Algerian, Egyptian, Iranian, Iraqi, Israeli, Kurdish, Lebanese, Moroccan, Syrian, etc.	
☐ Native Hawaiian or Pacific Islander	Chamorro, Chuukese, Fijian, Mashallese, Tongan Native Hawaiian, Palauan, Samoan, Tahitian, etc.	
☐ Multiple Races: Check all that apply above.		

SEXUAL ORIENTATION & GENDER IDENTITY[4]

Part 1: Sexual Orientation

Lesbian	Bisexual	Something Else:
Gay	Queer	Don't Know
Straight or heterosexual	Pansexual	Prefer not to answer

Part 2: Current Gender Identity

Female/woman/girl	Transgender female/woman/girl	Don't know
Male/man/boy	Transgender male/man/boy	Prefer not to answer
Nonbinary, genderqueer, or not exclusively female or male	Another gender:	

Sex assigned at birth (on your original birth certificate)

Female	Male	X/Another sex:	Don't know	Prefer not to answer

PARTICIPATION SUPPORTS

Check all the support(s) you need to participate for meetings. (If something is missing, please use the "Other" option to write it in.)

☐ American Sign Language (ASL) ☐ CART services ☐ Language Interpretation: Yes or No ○ If yes, Which one? ☐ Print Materials: Large font	☐ Seating: up front, aisle access, other ☐ Technology: Phone or tablet for meeting surveys ☐ Transportation ☐ Other:

Do you have any dietary requirements or allergies?

☐ None	☐ Vegetarian	☐ Gluten free
☐ Peanut allergy	☐ Vegan	☐ Other

Anything else you would like to share with the DMH and DPH-SAPC Administration Team regarding yourself for consideration as a member of the BHSA Community Planning Team?

[4] Adapted from National LBGTQIA+ Health Education Center – A Program of the Fenway Institute. *Ready, Set, Go! A Guide for Collecting Data on Sexual Orientation and Gender Identity.* Downloaded on March 1, 2025. https://www.lgbtqiahealtheducation.org/wp-content/uploads/2022/05/TFIE-64_Updates2022_ReadySetGo_10_18_22.pdf