

COUNTY OF SANTA CRUZ, MENTAL HEALTH SERVICES ACT
2010—2011 MHSA PLAN UPDATE

PUBLIC COMMENT FORM

Personal Information (Optional)

Name: _____

Agency/Organization: _____

Phone Number: _____ Email: _____

Mailing Address: _____ City: _____

My Role in the Mental Health System (Please check one):

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Consumer/Client/Youth | <input type="checkbox"/> Education | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Probation | <input type="checkbox"/> Law Enforcement/Criminal Justice |
| <input type="checkbox"/> Service Provider/Contractor | | |
| <input type="checkbox"/> Other: _____ | | |

What do you see as the strengths of this Plan Update (use other side of this form as needed)?

If you have any concerns about this Plan Update, please explain (see other side of this form as needed).

THANK YOU FOR YOUR FEEDBACK!

The Mental Health Services Act (MHSA)

Santa Cruz County Health Services Agency,
Mental Health & Substance Abuse Services Division
1400 Emeline Avenue, Santa Cruz, CA 95060



www.santacruzhealth.org
(831) 454-4931 or (831) 454-4498