Form also available at: www.ctmhp.org

Date: ______________________

MEMBERSHIP REGISTRATION FORM- Please Print

Name: ____

Title: ____

Agency/Business Name: ____

Mailing Address: ____

____

Telephone: (___) _________**Fax:** (___) __________**Alternate phone**:(___)________

Email: ____

Primary language:________________ **Secondary language**:_________________

By submitting this form, you are asking the CMHP to **join or confirm Membership** in the CT Multicultural Health Partnership. After completing this form, you will be contacted by someone at the CMHP and also added to our mailing lists. Contact us with questions.

- "**I am already a member** of the Partnership and I would like to get more involved a Committee": ☐ **Yes** ☐ **No**
- I would like to **join the following Committee** (Please check one):

☐ Awareness & Outreach ☐ Communication and Media

☐ Consumer Initiatives ☐ Data Surveillance and Evaluation

☐ Professional Development ☐ Language Services

May we have your permission to publish your name, agency name and e-mail in a member directory? ☐ **Yes** ☐ **No**

The following information is required by the US-DHHS-Office of Minority Health for funding and evaluation purposes towards eliminating Health Disparities. We appreciate your time and thank you for your cooperation.

Continued on next page.

Please select the categories that best describe you below:

YOUR TYPE OF ORGANIZATION REPRESENTS (check one of the following categories):

☐ **A. Public Institutions (Check One):**
Check one: Local ☐ State ☐ Federal ☐ Tribal Entity/government ☐

☐ **B. Institutions of Higher Education (Check one):**
Historically Black College/ University ☐
Hispanic Serving Institution ☐
Tribal college/ University ☐
Other College/ University ☐

☐ **C. Minority-Serving Community- based organization (Check one):**
Non-health Focused ☐
Health Focused ☐
Heath care entity ☐
Faith based organization ☐
Other ☐ ___________________________________

☐ **D. National Minority Serving Organization (Check one):**
Non-health focused ☐
Health focused ☐
Heath care entity ☐
Faith based organization ☐
Other ☐ ___________________________________

E. ALL: If you elected a Health Care area above, can you please specify the following for your occupation:
a .Community Health Worker:____________________
b. Nurse:_____________________________________
c. APRN/PA:__________________________________
d. Clinical Social Worker:______________________
e. Physician:_________________________________
f. Administrator:______________________________
g. Other:_____________________________________

☐ **Are you Community Member/ Advocate (Check if yes, specify):____________________**

☐ **Are you a student? (Check if yes, specify level/year):_____________________________**

Continued on next page.

F. INVOLVEMENT WITH THE CMHP:

1. How did you first learn about the CMHP?

___Email notice ____CHMP Website ___ CHMP event
___Another Member ____CHMP Postcard ___ CMHP's Educational Materials

___**Other**:____

2. Please briefly describe the nature of skills, experiences and/or interests you/your organization intend to bring to the Partnership:

____
____
____
____

3. Briefly tell us your main personal or professional motivation for becoming a member of the CMHP. (I.e., what do you hope to do, or contribute to the CMHP, and what might the CMHP do for you or your organization?).

____
____
____
____

4. The CT DPH Office of Multicultural Health is compiling a list of speakers who are able to speak and present on various Multicultural Health and Disparities Issues. If you are able and interested in speaking/presenting please describe your expertise/areas of interest:

____
____
____
____

5. Only if applicable, are you or will you be acting as a Partner in providing the following? (Check all that apply):

_____Paid Staff % Time if known_________ $ contribution if known ______
_____Volunteer Staff % Time if known_________ $ contribution if known ______

6. Other Resources, Please Describe:

____
____

DEMOGRAPHICS

G. Geographic Area Served by Your Work (Check all that apply):

☐ Fairfield County ☐ Hartford County ☐ Middlesex County ☐ New Haven County
☐ New London County ☐ Litchfield County ☐ Tolland County ☐ Windham County
☐ STATEWIDE

Continued on next page

H. If applicable, please estimate of "race"/ethnicities and ages of the consumer populations served by your work or organization?

(Rank Largest to Smallest numbers of clients served for each list, using numbers # 1-7, and "0" if not applicable).

1. "Race"/Ethnicity:

- ☐ Non-Hispanic/Latino- White/Caucasian
- ☐ Non-Hispanic/Latino- Black/ African-American
- ☐ Hispanic/Latino
- ☐ American Indian/ Alaskan Native
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Asian
- ☐ Other:______________________________
- ☐ Optional Comments:_________________________

____

2. By Age group:

- ☐ Newborn to 1 year
- ☐ 1-5 years
- ☐ 6-12 years
- ☐ 13-17 years
- ☐ 18-24 years
- ☐ 25-64 years
- ☐ 65 or over

3. Gender (Total of all percentages should equal 100%):

☐ % Female ☐ % Male ☐ Other

I. Member / Contact- Your own identified "Race"/Ethnicity:

- ☐ Non-Hispanic/Latino- White/Caucasian
- ☐ Non-Hispanic/Latino- Black/ African -American
- ☐ Hispanic/Latino
- ☐ Other:________________________________
- ☐ American Indian/Alaskan native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Asian
- ☐ Choose not to answer

Country of Origin ____________________ **Optional Comment:**____________________________

J . Your Age group:

- ☐ 13-17 years
- ☐ 18-24 years
- ☐ 25-64 years
- ☐ 65+ years
- ☐ Choose not to answer

J. Your Gender

- ☐ Female
- ☐ Male
- ☐ Other______________
- ☐ Choose not to answer

PARTNERS: Please mail, fax, or email entire form (4 pages) to:
Angela Jimenez, Office of Multicultural Health, CT Dept. of Public Health, MS #11 OMH, 410 Capitol Avenue, Hartford CT 06106 Tel (860) 509-7140, Fax (860) 509-7853
Email: angela.jimenez@ct.gov Form Updated 08/08/2013

(For CMHP Staff only) Type of Membership
__Informal/ Verbal Agreement
__Letter of Invitation/ Letter of Acceptance
__Memorandum of Understanding/Agreement
__Subcontract
__Other
DATE RECEIVED:_________**STAFF:**__________

(For CMHP Staff only)
_____Total % FTEs on project (to nearest .25)
__FT __PT __Consultant __Contractor
__Fee For Service Staff ___Volunteer (unpd.)

__Other:_______________________________