



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):

- | | |
|---|---|
| <input type="checkbox"/> Awareness & Outreach | <input type="checkbox"/> Communication and Media |
| <input type="checkbox"/> Consumer Initiatives | <input type="checkbox"/> Data Surveillance and Evaluation |
| <input type="checkbox"/> Professional Development | <input type="checkbox"/> Language Services |

May we have your permission to publish your name, agency name and e-mail in a member directory? **Yes** **No** **Not Sure**

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
Health care entity
Faith based organization
Other _____

D. National Minority Serving Organization (Check one):
Non-health focused
Health focused
Health 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

Optional Comment: _____

J. Your Age group:

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

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 #13 OMH,
410 Capitol Avenue, Hartford CT 06106 Tel (860) 509-7140, Fax (860) 509-7160
Email: angela.jimenez@ct.gov

(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: _____