

The Division of Behavioral Health  
Community Coalition Application

Please complete this form to register your coalition with the Division of Behavioral Health. If you have questions regarding this form, please contact [prevention@dmh.mo.gov](mailto:prevention@dmh.mo.gov).

What type of application is this? (Please check one)

☐New

☐Update

1. Date:

2. Coalition Name:

Coalition Leader's Name:

Street Address:

Mailing Address:

City:

Zip Code:

Phone Number:

County:

Email:

Website:

3. Please state the coalition's mission:

Please list the coalition's goals and objectives:

4. Please provide a list of the coalition members' names.

Types of team members: (check all that apply)

☐Youth (18 and under)

☐Parents

☐Business

☐Media

☐Schools

☐Youth serving organizations

☐Law enforcement

☐Civic and volunteer groups

☐Faith or fraternal organizations

☐State or local government agencies

☐Healthcare professionals

☐Other organizations involved in reducing substance use

5. How long has the coalition been in existence?

☐Less than a year    ☐1-2 years    ☐3-4 years    ☐5 or more years

6. Does the coalition meet on a quarterly basis at a minimum?

☐ Yes ☐ No

7. Describe the geographic area served by the coalition by identifying the counties, cities, school districts, zip codes, census tracts, or block groups fully served.

8. Has your coalition conducted a community needs assessment? If yes, when?

☐Past year    ☐Past 2 years    ☐Past 3 years    ☐Never    ☐Other

9. Does the coalition support or implement an evidence-based program or best practice?

☐Yes ☐No

If so, please list the program(s)/best practice(s)?

10. What type of activities does your coalition plan and support?

<input type="checkbox"/> Advocacy	<input type="checkbox"/> Afterschool programs
<input type="checkbox"/> Mentoring programs	<input type="checkbox"/> Youth conferences
<input type="checkbox"/> Prom/Graduation/Alternative activities	<input type="checkbox"/> Policy initiatives
<input type="checkbox"/> Media campaigns	<input type="checkbox"/> Other (please list)

11. Please list the coalition's current funding sources.

12. Is your coalition a CADCA registered coalition?

☐ Yes ☐No

13. Does the coalition perform evaluation outcomes measurement to determine the effectiveness of programs and activities?

☐ Yes ☐No

If so, please identify the evaluation process.

☐I am aware that the information provided may be posted on the Department of Mental Health website and viewed by the general public.

☐I have included a coalition meeting schedule and the coalition's most recent meeting minutes.

Name of individual completing this application\_\_\_\_\_