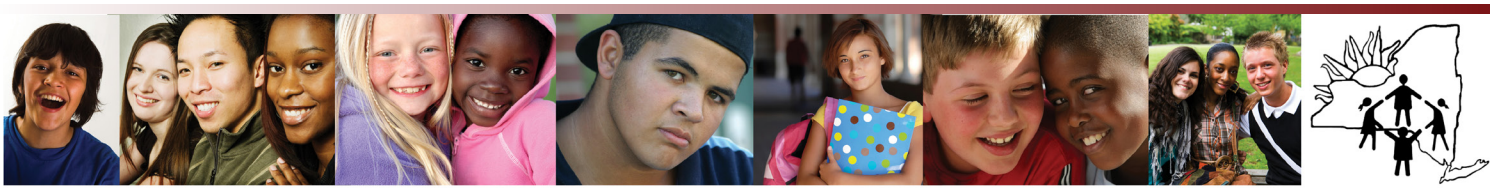

NEW YORK STATE COALITION FOR CHILDREN'S BEHAVIORAL HEALTH

Allied Membership APPLICATION

for non-OMH licensed or certified provider organizations

Please complete and return to info@cbhny.org

DUES FOR 2016: $2,000

☐ Community Based Organization	☐ County SPOA	☐ Family/Children's Advocacy Organization
☐ Health Home	☐ Hospital/Health Care System	☐ Managed Care Organization
☐ Primary Care/Pediatrics	☐ Substance Use Providers	☐ University

Other (please describe)_____

Executive Director/CEO:_____
Title: _____
Organization Name: _____
Address: _____
City:_____ State:_____ Zip:_____
Phone: _____ E-mail: _____
Company Website:_____

Signature:_____ Date:_____

Bill To:
Name: _____ or same as above:____
Title: _____
Organization Name: _____
Address: _____ or same as above:____
City:_____ State:_____ Zip:_____
Phone: _____ E-mail: _____

Primary Contact:_____ or same as above:____
Title: _____
Organization:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone: _____ E-mail: _____

2016 Allied Membership Dues	2016 Dues
☐ Payment in full for 2016	$2,000.00

Dues are annual and calendar based. Dues Are Incurred Until We Are Notified In Writing To Terminate Your Membership.

Please complete and return to
info@cbhny.org by January 31, 2016.
If you have any questions, please contact info@cbhny.org.

Total Payment Enclosed $_____

☐ Check Enclosed Check # _____
☐ Voucher Voucher # _____
☐ Purchase Order PO # _____