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: $3,000

☐ 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: ____________________

Allied Membership Dues	Dues
☐ Payment in full for ____(year)	$3,000.00

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

Total Payment Enclosed $____________

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

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

7/2018