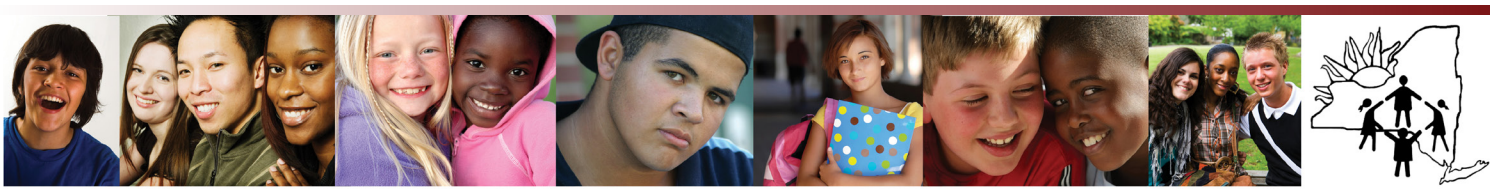

NEW YORK STATE COALITION FOR CHILDREN'S BEHAVIORAL HEALTH

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
- ☐ Membership Association
- ☐ University
- ☐ Research/Foundations/Philanthropy Organizations

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.

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

Total Payment Enclosed $_____

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

1/2020