Provider Member APPLICATION

for OMH Licensed, Certified or Designated Agencies

NEW YORK STATE COALITION FOR CHILDREN'S BEHAVIORAL HEALTH
P.O. BOX 7124, ALBANY, NY 12224 518-436-8715 WWW.CBHNY.ORG INFO@CBHNY.ORG

DUES: Dues are calculated based on each of your agency's total childrens mental health budgets based on services below. Please check off the services provided by your agency. Please calculate your total children's mental health budgets, per service area, as reported on your most recently filed CFR. Agency dues are calculated based on the total mental health budget per the ranges outline in the chart below. Please note: The Coalition may verify services and total expenditures per OMH CFR available information.

- ☐ Advocacy/Support Services
- ☐ Affirmative /Business Industry
- ☐ Assertive Community Treatment
- ☐ Blended Case Management
- ☐ Care Coordination/Care Management
- ☐ Children and Family Treatment & Support Services (CFTSS)
- ☐ Clinic
- ☐ CPEP Crisis Outreach
- ☐ Crisis Residential & Respite Beds
- ☐ Day Treatment
- ☐ Family Peer Support Services
- ☐ HCBS Service Array
- ☐ Health Home Care Management
- ☐ Intensive Case Management
- ☐ Partial Hospitalization
- ☐ Respite Services
- ☐ Residential Treatment Facilities
- ☐ Services Single Point of Access (SPOA)
- ☐ School Based Mental Health
- ☐ Performance Based Early Recognition and Screening
- ☐ Transition Management
- ☐ Vocational and Educational
- ☐ Other (please describe) _____

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

Signature: _____ Date: _____

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

Contact Name: _____ Title: _____
Organization: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone: _____ E-mail: _____

Contact Name: _____ Title: _____
Organization: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone: _____ E-mail: _____

CHILDRENS BEHAVIORAL HEALTH PROVIDER DUES CHART

$ Total Childrens Behavioral Health Budget		Dues	
HCBS Service Array and CFTSS		$4,000	☐
0	1,000,000	$3,000	☐
1,000,001	3,000,000	$4,000	☐
3,000,001	5,000,000	$5,000	☐
5,000,001	7,000,000	$6,000	☐
7,000,001	11,000,000	$8,500	☐
11,000,001	15,000,000	$11,000	☐
15,000,001	18,000,000	$25,000	☐
18,000,001	20,000,000	$30,000	☐
20,000,001	70,000,000	$35,000	☐

New Provider Membership Dues ~ *Dues are annual and calendar based. Dues are incurred until we are notified In writing to terminate your membership.*

☐ Payment in full

Total Payment Enclosed $_____

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

Please complete and return to ***jackienegrillc@gmail.com***
If you have any questions, please contact jackienegrillc@gmail.com