

# 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



**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.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Advocacy/Support Services                                | <input type="checkbox"/> CPEP Crisis Outreach              | <input type="checkbox"/> Respite Services                                  |
| <input type="checkbox"/> Assertive Community Treatment                            | <input type="checkbox"/> Crisis Residential & Respite Beds | <input type="checkbox"/> Residential Treatment Facilities                  |
| <input type="checkbox"/> Blended Case Management                                  | <input type="checkbox"/> Day Treatment                     | <input type="checkbox"/> Services Single Point of Access (SPOA)            |
| <input type="checkbox"/> Care Coordination/Care Management                        | <input type="checkbox"/> Family Peer Support Services      | <input type="checkbox"/> School Based Mental Health                        |
| <input type="checkbox"/> Children and Family Treatment & Support Services (CFTSS) | <input type="checkbox"/> HCBS Service Array                | <input type="checkbox"/> Performance Based Early Recognition and Screening |
| <input type="checkbox"/> Clinic   | <input type="checkbox"/> Health Home Care Management       |  |
| <input type="checkbox"/> Other (please describe)                                  | <input type="checkbox"/> Intensive Case Management         |  |

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	
0	1,000,000	\$4,000 <input type="checkbox"/>
1,000,001	3,000,000	\$5,000 <input type="checkbox"/>
3,000,001	5,000,000	\$6,000 <input type="checkbox"/>
5,000,001	7,000,000	\$7,000 <input type="checkbox"/>
7,000,001	11,000,000	\$9,500 <input type="checkbox"/>
11,000,001	15,000,000	\$12,000 <input type="checkbox"/>
15,000,001	18,000,000	\$26,000 <input type="checkbox"/>
18,000,001	20,000,000	\$31,000 <input type="checkbox"/>
20,000,001	70,000,000	\$35,000 <input type="checkbox"/>

**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](mailto:jackienegrillc@gmail.com)  
 If you have any questions, please contact [jackienegrillc@gmail.com](mailto:jackienegrillc@gmail.com)