



New York State Coalition for Children's Mental Health Services

PO Box 7124 Albany, New York 12224-0124 Phone: (518) 436-8715 Fax: (518) 427-8676
Serving New York's Children and Youth, Families and Communities

Please Print

Application for Membership for New Members

I would like membership in the Coalition:

DUES FOR 2011

TOTAL: \$2,000

Please note: As of 2012, a new dues restructuring formula will be implemented which is based on an agency's mental health budget.

DATA	No. of Sites/Slots
_____ Community Residence	_____ sites
_____ Home and Community Based Waiver	_____ slots
_____ Clinic	
_____ Other (please describe) _____	

Dues Are Incurred Until We Are Notified In Writing To Terminate Your Membership.

Executive Director/CEO: _____
Title: _____
Organization Name: _____
Address: _____

Phone: _____ **Fax:** _____ **E-mail** _____

SIGNATURE: _____ **Date:** _____

Bill To - **Name:** _____ **Same as Above:** _____
Title: _____
Organization Name: _____
Address: _____ **Same as Above:** _____

Phone: _____ **Fax:** _____ **E-mail** _____

Please indicate the type and # of beds for each program with contact and site info, if different from above:
(If you have more than three programs to list, please make a copy of this application to complete the necessary information)

_____ **CR** _____ **HCBW** **Number of Beds/Slots:** _____
Contact: _____ **Same as Above** _____
Title: _____
Org Name: _____
Address: _____ **Same as Above** _____

Phone: _____ **Fax:** _____ **Email** _____

_____ **CR** _____ **HCBW** **Number of Beds/Slots:** _____
Contact: _____ **Same as Above** _____
Title: _____
Org Name: _____
Address: _____ **Same as Above** _____

Phone: _____ **Fax:** _____ **Email** _____