THE ALLIANCE OF COMMUNITY SERVICE PROVIDERS

MEMBERSHIP APPLICATION FORM

NAME OF ORGANIZATION: _____

CEO/EXECUTIVE DIRECTOR: _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP+4**: _____

PHONE: _____ **FAX:** _____ **E-MAIL**: _____

PRIMARY CONTACT: _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP+4:** _____

PHONE: _____ **FAX**: _____**E-MAIL:** _____

ORGANIZATION'S REVENUE – Refer to the current Dues Schedule

Kindly complete-- ***DO NOT include income from other than Philadelphia DBHIDS and PROMISe. Funds from other sources, such as Philadelphia DHS contracts, other counties, etc. are not used in the dues calculation.***

Philadelphia County Contracts: in Mental Health	$ _____
Philadelphia County Contracts with OAS	$ _____
Community Behavioral Health (CBH) Billings	$ _____
Billings against BHSI	$ _____
"Philadelphia Revenue" in Intellectual Disabilities	$ _____
PROMISe Payments for ODP clients from Philadelphia Or services located in Philadelphia	$ _____
TOTAL "PHILADELPHIA" REVENUE	**$** _____

*For your reference the **DUES SCHEDULE** is included on the following page. Do not include a dues check with this application; The Alliance will invoice your agency after approval. Thank you.

Approved for 18/19 FY