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: Please fill out the information below. 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 $ _______________________

* Do not include a dues check with this application; The Alliance will invoice your agency after approval.
Thank you.