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.