



**Allied Member Application
Dues Year - 2017 / 2018**

Allied members work in partnership and have common interests with TBI and NHTD waiver providers. Allied members include not-for-profit and public organizations that do not provide waiver services directly, or products and/or services to TBI / NHTD waiver providers; however, support the mission and efforts of the Alliance.

Choose one: New Allied Member Renewing Allied Member

Month/Day/Year: _____

Agency Information

Agency name: _____ Website: _____

Address: _____ City / State / Zip: _____

Phone: _____ Fax: _____

Type of business: _____

Membership Contacts

CEO / Executive Director: _____ Email: _____

Main Membership Contact Name & Title: _____

Contact Phone #: _____ E-mail: _____

Allied Member Benefits

- Receive all provider membership mailings, emails, and publications;
- Discounts on exhibitor booth rates for Alliance events;
- Discounted rates on Alliance print and website advertising;
- Discounts on Alliance conferences, trainings, and webinars;
- Access to Alliance Membership Directory that includes membership contact information;
- Access to Members Only section on our website;
- Listing of your business, products/services, & contact information on Alliance website; and
- Participation in Alliance membership meetings and advocacy efforts.

Allied Member Dues Payment

\$250.00 Amount Enclosed: _____

Products and/or services provided (please check all categories that you would like your company listed as providing under the Member section of the Alliance website):

<input type="checkbox"/> Advocacy <input type="checkbox"/> Behavioral Health Services <input type="checkbox"/> Benefits Advisement <input type="checkbox"/> Case Management <input type="checkbox"/> Consumer Directed Services <input type="checkbox"/> Disease Management types: _____ _____ _____ _____	<input type="checkbox"/> Information and referral <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Social Security Disability Advocacy <input type="checkbox"/> Substance Abuse Services <input type="checkbox"/> Support groups types: _____ _____ _____	<input type="checkbox"/> Other: _____ _____ _____ _____
---	--	--

Please provide a 40 word or less description of your products and/or services to be listed in Alliance publications. _____

*****REQUIRED SIGNATURE*****

I certify that I am an authorized representative of my agency and am affirming its membership in the Alliance of TBI & NHTD Waiver Providers. I agree to receive information/updates/announcements from the Alliance via mail, email, or fax. I understand that membership in the Alliance is for one full year and agree to pay the full amount of the annual dues.

Agency authorized person's name (please print): _____

Signature _____ Date: _____

Please send completed, signed membership contract and dues payment to:

The Alliance of TBI & NHTD Waiver Providers
4381 Tannery Road
Campbell, New York 14821

Membership benefits will not be granted until a signed contract *and* dues payment are received.

For questions about your application, please contact
 Traci Allen, Executive Director, at tallen@alliance-nys.org