Associate Member Application
Dues Year – 2017 / 2018

Associate members include providers of products and/or services to provider members – including but not limited to medical supply companies, consulting firms, computer software companies, etc.

Choose one: [ ] New Associate Member [ ] Renewing Associate 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: _____

Associate 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.

Associate Member Dues Payment

[ ] **$500.00** **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):

[ ] Accounting [ ] Accreditation [ ] Advocacy [ ] Answering Service [ ] Banking [ ] Billing [ ] Claims Management [ ] Communications [ ] Computer Hardware [ ] Contractor / Remodeling Services [ ] Corporate Compliance Planning [ ] Durable Medical Equipment [ ] Education [ ] Employee Recruitment and/or Screening [ ] Employment & Benefits [ ] Executive Search [ ] HIPAA compliance	[ ] Information Systems [ ] Information Technology System [ ] Insurance [ ] Leadership Assessment [ ] Legal [ ] Licensure/Start-up [ ] Managed Care [ ] Management Consulting [ ] Marketing / Advertising [ ] Medical Product Supplier [ ] Medical Transportation [ ] Non-Medical Transportation [ ] Nursing / Clinical Consulting [ ] Office Supplies [ ] Payroll [ ] PERS [ ] Pharmaceutical supplies [ ] PRI / Screen Assessments [ ] Printing [ ] Publishing	[ ] Quality Improvement [ ] Software supplier [ ] Strategic Planning [ ] Telehealth [ ] Telephony [ ] Training types: _____ _____ _____ _____ _____ [ ] UAS-NY Assessments [ ] Website design and/or management [ ] 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