Allied Member Application
Dues Year – 2024 / 2025

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):

[ ] Advocacy [ ] Behavioral Health Services [ ] Benefits Advisement [ ] Case Management [ ] Consumer Directed Services [ ] Disease Management types: ____________________ ____________________________ ____________________________ ____________________________	[ ] Information and referral [ ] Mental Health Services [ ] Physical Therapy [ ] Social Security Disability Advocacy [ ] Substance Abuse Services [ ] Support groups types: ____________________ ____________________________ ____________________________	[ ] 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