Provider Member Application
Dues Year – 2024 / 2025

Choose one: [ ] New Provider Member [ ] Renewing Provider Member

Month/Day/Year: _____

Agency Information

Agency name: _____Website: _____

Address: _____ City / State / Zip: _____

Phone: _____ Fax: _____

Waiver Served: [ ] TBI [ ] NHTD [ ] Both Region(s) served: _____

Membership Contacts

CEO / Executive Director: _____ Email: _____

Main Membership Contact Name & Title: _____

Contact Phone #: _____ E-mail: _____

Dues Payment

Alliance provider membership dues are for a calendar year and are based on the agency's **total operating budget.**

Alliance Dues Structure for April 1, 2024 – March 31, 2025

Total Agency Operating Budget	Provider Dues Amount
10 Million or greater	$1400.00 per year
$5,000,000 - $9,999,999	$1250.00 per year
$1,500,000 - $4,999,999	$900.00 per year
$700,000 -$1,499,999	$650.00 per year
699,999 or less	$350.00 per year

Current Agency Total Operating Budget: _____ **Total Dues:** _____

Amount Enclosed: _____

PROVIDER MEMBER CONTRACT TERMS AND CONDITIONS

1. I certify that I am an authorized representative of my agency, which is a New York State Department of Health approved Traumatic Brain Injury and/or Nursing Home Transition and Diversion Waiver provider.
2. I understand that by accepting this statement my agency is affirming its membership in the Alliance of TBI & NHTD Waiver Providers.
3. My agency agrees to adhere to the By-laws of the Alliance of TBI & NHTD Waiver Providers, and the decisions of its Board in accordance with said By-laws.
4. I understand that the name of my agency may appear publicly on Alliance related materials.
5. I agree to receive information/updates/announcements from the Alliance via mail, email or fax.
6. I understand that my membership in the Alliance is for one full year and agree to pay the full amount of the annual based on my agency's operating budget.
7. I certify that the dues amount selected reflects my agency's total operating budget.
8. This membership agreement shall remain in place for one calendar year, until a written request of discontinuation is received by either party, or in the event the rules of membership are amended through a revision to the By-laws.

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

Organization: _____

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 (607) 329-0507 or email tallen@alliance-nys.org