

**Membership Renewal/Application July 1, 2011 – June 30, 2012**  
**Please complete and return this entire form**

Agency Name: \_\_\_\_\_

\*Executive Office Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Web: \_\_\_\_\_

- **Please enclose a brochure or other document showing the names and addresses of all services and facilities.**

Agency Executive: \_\_\_\_\_ Title: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Phone: \_\_\_\_\_

What age groups does your agency serve? Children Adolescents Transition Adults Older Adults

What services does your agency provide? (Please check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Partial Hospitalization/Day Treatment | <input type="checkbox"/> Wrap-around/FSP                      | <input type="checkbox"/> Special Education          |
| <input type="checkbox"/> Substance Use/Co-Occurring            | <input type="checkbox"/> Outpatient                           | <input type="checkbox"/> Inpatient                  |
| <input type="checkbox"/> Crisis Stabilization                  | <input type="checkbox"/> Residential (no. of beds _____)      | <input type="checkbox"/> Supported Housing          |
| <input type="checkbox"/> Case Management                       | <input type="checkbox"/> Vocational Rehabilitation Services   | <input type="checkbox"/> Integrated Services Agency |
| <input type="checkbox"/> MHSA PEI                              | <input type="checkbox"/> Health Home/On site Health Screening |   |

Other: \_\_\_\_\_

How many clients did your agency serve last year? \_\_\_\_\_

Do you provide Mental Health Services in other counties? \_\_\_ No \_\_\_ Yes

List counties \_\_\_\_\_

(1) Total Mental Health Revenue\* \$ \_\_\_\_\_ (based on agency's total mental health revenue as it appears on your most recent fiscal year cost report – rounded to the nearest \$100,000)

(2) Total county MH contract(s) \$ \_\_\_\_\_

(3) Total operating budget \$ \_\_\_\_\_ (this is **not** necessarily the total of the two lines above)

\*Includes federal, state and county funding for MH services, as well as client-paid, managed care and insurance payments and other third-party payors

**Dues for renewing members are due by July 31, 2011.**

**New members** joining between July 1, 2011 and March 31, 2012: Dues are prorated based upon the number of full + partial months remaining. For new members joining between April 1 and June 30, 2012, there is no charge for the remaining months of the current year once dues for the following year are paid in full.

Agency Name: \_\_\_\_\_

**2011-2012 CCCMHA Dues Calculator/Invoice**

(includes regular dues plus special assessment)

CCCMHA dues are based upon an agency's **total mental health revenue** (Line 1). Charitable contributions and funding for services not related to mental healthcare are not included in computing your dues.

**Using the figure from line 1, if your total Mental Health Revenue is:**

**Under \$2 million\***

**\$2 Million or Over\*\***

A) Base rate =	\$ 400	A) Base rate =	\$ 5,400
B) Multiply .0025 x your total Mental Health Budget (Line 1)	\$ _____	B) Add \$225 for each additional \$1 million over \$2M (Line 1)	\$ _____
C) Total Dues = <b>A+B</b>	\$ _____	C) Total Dues = <b>A+B</b>	\$ _____

\* Minimum dues is \$650

\*\* Maximum dues is \$20,000

**Board-Approved Special Assessment 2011-2012**

**\$140 per \$1 million of mental health revenue = \$ \_\_\_\_\_**

**TOTAL DUES PAYABLE FOR 2011-2012 = Total of regular dues plus special assessment: \$ \_\_\_\_\_**

**Please submit a check for the calculated amount, payable to CCCMHA, and mail to the address above.**

*CCCMHA dues include membership in the National Council for Community Behavioral Healthcare.*

Dues payments are not deductible as charitable contributions; however, they may be deductible as ordinary and necessary business expenses. We estimate that 15% of your dues are used for activities classified as lobbying expenses and an additional 5% for grassroots lobbying.