



Michigan Association of

# COMMUNITY MENTAL HEALTH

Boards

<p align="center"><b>Michigan Association of CMH Boards Provider Alliance - Affiliate Membership Application</b></p>
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Organizational Name \_\_\_\_\_

Federal Tax ID# \_\_\_\_\_

Executive Director/CEO \_\_\_\_\_

Title as listed (ie CEO, President, Executive Director or combination of) \_\_\_\_\_

Chief Financial Officer \_\_\_\_\_

Street Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

e-mail address \_\_\_\_\_

web page address \_\_\_\_\_

Brief (2-3 Sentences) Description of Organization \_\_\_\_\_

Organization Gross Budget \_\_\_\_\_

**Provider Alliance dues are structured as follows:**

<b>Budgets up to \$2,499,999</b>	<b>\$443</b>
<b>\$2,500,000 to \$4,999,999</b>	<b>\$897</b>
<b>\$5,000,000 and above</b>	<b>\$2,473</b>

**The Association fiscal year is from Oct. 1<sup>st</sup> through Sept. 30<sup>th</sup>.**

[ ] Please process our application for Provider Alliance Membership.

I am an authorized representative of the above organization and hereby request that the Executive Board of the Michigan Association of CMH Boards accept this application for Affiliate Membership.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

[ ] Please send additional information on Provider Alliance Membership.

**Return this application to:**

Michigan Association of CMH Boards  
426 S. Walnut, Lansing, MI 48933  
517-374-1053 (Fax)