

# Membership Application

December 2015



## Contact Information

Organization Name:	
Street Address:	
City, State, Zip:	
Telephone:	
Website:	
CBH Liaison. Please identify the person who will be the official voting representative at all CBH meetings.	
Name:	
Title:	
Email:	
Telephone:	
Billing Contact. Please identify the person responsible for paying CBH annual dues.	
Name:	
Title:	
Email:	
Telephone:	
Leadership. If CBH liaison is not organization's director or CEO, please provide contact information.	
Name:	
Title:	
Email:	
Direct Telephone:	

## Membership Criteria

An organization meeting the following criteria may be considered for membership. Please circle yes or no for each question below.	
YES or NO	Organization is a private, non-profit corporation organized in Maryland. Federal Tax Exempt No: _____
YES or NO	Organization is a for-profit corporation organized in Maryland. Federal Tax Id No: _____
YES or NO	Organization is a local health department engaged in direct provision of mental health or substance abuse services.
YES or NO	Organization supports CBH's mission of enhancing quality and improving access to community-based behavioral health treatment in Maryland.



## Member Services & Directory Information

Please provide requested information below on range of services, number served by program, and program revenue for the most recent fiscal year.		Consumers served	Revenue
<b>Outpatient Behavioral Health Clinic</b>			
Service	Offered?		
24-hour mobile crisis response	YES or NO		
Outpatient mental health treatment	YES or NO		
Outpatient substance abuse treatment	YES or NO		
<b>Opioid Treatment Program</b>			
Service	Offered?		
Methadone or buprenorphine treatment	YES or NO		
Counseling	YES or NO		
<b>Specialty Behavioral Health</b>			
Service	Offered?		
Mobile treatment services	YES or NO		
Case Management	YES or NO		
Psychiatric Rehabilitation Program	YES or NO		
Vocational rehabilitation, including supported employment	YES or NO		
Peer or family support services	YES or NO		
Health Home	YES or NO		
Residential Rehabilitation Program			
Crisis Residential			
Respite Care			
Inpatient			
Other:			
<b>TOTAL BEHAVIORAL HEALTH REVENUE:</b>			\$ _____

## Dues Calculation

<p>CBH has three types of membership: full agency membership for those directly providing behavioral health services and affiliate membership for organizations who do not provide services but who support CBH's mission. To find your appropriate membership category and dues level, please complete the following questions.</p>	
<p>YES or  NO</p>	<p><b>Full Agency Membership.</b> Does your organization provide one or more of the behavioral health services listed above?</p> <p>If no, skip to next YES or NO question.</p> <p>If yes, then you are eligible for full, voting membership in CBH. Dues are progressively assessed based on your behavioral health revenue. Calculate your dues:</p>



	1. Take your first \$3 million in revenue and multiple it by 0.0023 =	\$ _____
	2. Multiply the balance up to \$10 million by 0.001 =	\$ _____
	3. Multiply the balance over \$10 million by 0.005 =	\$ _____
	4. <b>Total dues</b> , add lines 1-3 =	\$ _____
YES or NO	<b>Affiliate Membership.</b> Organization does not provide direct mental health, substance abuse or addiction services, or related support services, but supports CBH's mission of improving the quality of care and increasing access to treatment.  If yes, you are eligible for nonvoting, affiliate membership with CBH.	
	If annual revenue is less than \$250,000, dues are =	\$ 750
	If annual revenue is more than \$250,000, dues are =	\$ 5,000
YES or NO	<b>Corporate Membership:</b> Acts as a premier sponsor to support the mission of CBH, and receives special recognition at the annual conference and in CBH publications.	
	Dues are =	\$10,000

## Required Attachments

Please submit copies of the following documents with your membership application:	
Most recent Audited Financial Statement for organization	
Program brochure	
Current statement of program revenue	

Please return this completed application and required attachments with a cover letter to:

Community Behavioral Health Association of Maryland  
18 Egges Lane, Catonsville, MD 21228

Membership is approved by a majority vote of the Board of Directors. You will be notified of your membership status as soon as a vote has been taken. If you have any questions, please contact Christine Kopco, Office and Member Services Manager, at [chris@mdcbh.org](mailto:chris@mdcbh.org) or (410) 788-1865.

## Signature

\_\_\_\_\_  
Chief Executive Officer

\_\_\_\_\_  
Date