Illinois Association for Behavioral Health

## AGENCY MEMBERSHIP APPLICATION FORM

Please list your chief executive officer and any other program administrator who should receive agency mailings.

**1. Agency Main Office** DHS Region _____

Name and Title: _____

Agency _____

Address _____
Street City State Zip

Phone ( )_____ Fax ( )_____

E-Mail Address _____ Website: _____

Legislative Coordinator (Name & Title)_____

Address & Phone (if different from above) _____

County(ies) Served _____

Main Office Legislative Info:

Senate Dist. _____ House Dist. _____ US Congressional Dist._____

Other Legislative Districts Served:

Senate Dist. _____ House Dist. _____ US Congressional Dist._____

Other Agency Location(s)/(branches) – Attach another sheet of paper if there is more than one branch location.

Name and Title _____

Address _____
Street City State Zip

Phone ( )_____ County(ies) Served: _____

**2. Referred By (if applicable):** _____

**3. Financial Information: Please provide accurate budget numbers and we will contact you with the amount owed for annual dues.)**

Annual Addiction & Mental Health Services Budget $_____

Our agency will pay membership dues: Annually Semi-Annually Quarterly

I hereby certify that the information contained in this application is true and correct to the best of my knowledge and belief.

Signature of Chief Executive Officer: _____ Date_____

Please return this form to: **IABH, 937 South Second Street, Springfield, Illinois 62704**