Blanca Campos, MPA, CAE
Chief Executive Officer
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Springfield, Illinois 62703
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FY'25 CBHA Membership Application

1. Agency Information

Executive Director/Administrator: _____

Agency Name: _____

Administrative Address: _____

City, State, Zip Code: _____

Area Code, Telephone Number: _____

FEIN Number _____

2. Agency Budget Information

Please indicate the total amount of your FY24 budget for mental health and/or substance use services. Only funds you received from state departments/agencies (grants and Medicaid) $_____.

3. Audited financial statement

Enclose a copy of your most recent audited annual income/expense activity. If your audit will not be complete for a period of time, please return your renewal form and return your audit upon completion.

4. Dues Assessment

Please state the category from the 'Dues Assessment Schedule' that coincides with your agency's budget. (NOTE: You may leave this area blank and CBHA will determine and communicate with you the appropriate dues category. _____

A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11	A12
A13	A14	A15	A16	A17	A18	A19	A20	A21	A22	A23	A24
B1	B2	B3	B4	B5	B6	B7	B8	B9	B10	B11	B12
B13	B14	B15	B16	B17	B18	B19	B20	B21	B22	B23	B24

5. Payment Options

Check the box that applies to your agency's payment option:

☐Annual payment
☐Semi-annual payment
☐Payment Enclosed
☐Quarterly
☐Other (please specify)
☐Bill Agency (dues will be billed upon receipt of form)

PLEASE RETURN TO NTHOMPSON@CBHA.NET.

CBHA appreciates your support and we look forward to another productive year.
* This information will remain confidential.
**CBHA is a 501(C)(4) organization. Membership dues are not deductible as charitable contributions for federal income tax purposes.