— FFTA Membership Application —

Organization Name ____________________

Primary Contact ____________________

Title ____________________

Address ____________________

City ____________________ State/Province ____________________

Zip/Postal Code ____________________ Country ____________________

Phone ____________________ Web site ____________________

E-mail ____________________

Organization Executive Director ____________________

Agency's annual family-based treatment program budget ____________________

For the last fiscal year, provide approximate figures for:

- total number of children/youth served across all agency programs ____________________
- total annual operating budget across all agency programs ____________________
- total number of full-time staff employed by your agency ____________________
- total number of licensed foster parents *(whether or not they have children placed in their home)* ____________

Membership Type: ❑ Full ❑ Multi-Site ❑ Affiliate

How did you hear about FFTA? ____________________

Is your agency accredited? ❑ Yes ❑ No If yes, by whom? ____________________

Payment Type: ❑ Check ❑ Visa ❑ MasterCard ❑ American Express Payment Amount: ______________

Account#: ____________________ Expiration Date: ______________ CSC Code: ___________

Billing Address (if different than above): ____________________

Name on card: ____________________ Signature: ____________________

FFTA Federal Tax ID# 363593908

Please mail application and payment (U.S. Funds) to:
Family Focused Treatment Association
210 River Street, Suite 23, Hackensack, NJ 07601-7504 USA

Family Focused Treatment Association

Call: 800-414-3382 ▪ Fax: 201-489-6719 ▪ Email: ffta@ffta.org ▪ Visit: www.ffta.org