



FY 17-18

organizational
membership

Florida Council for Community Mental Health
Florida Council for Behavioral Healthcare



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Organizational Membership Application | FY 17-18

Agency/Organization Name

Executive Director/CEO

Agency Mailing Address

Agency Phone Number

Agency Fax Number

Agency Website

Email Address

Number of Employees

Number of Clients Served

Number of Medicaid Clients Served Annually (Unduplicated)

My organization is accredited. Yes No

If so, by whom?

My organization is working toward accreditation. Yes No

If so, by whom?

see page two 

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Information Needed:

To process your agency membership application, the Council's Board of Directors also requests the following information:

- A copy of your agency's mission statement.
- A one page (or less) summary describing your agency's size, service area, and the types of services offered and to whom.
- Total revenue for fiscal year 2015-2016 to assess membership dues.

Please list additional leadership to be included on our email distribution:

Contact Name

Contact Name

Contact Name

Contact Name

Contact Name

Contact Name