National Association for Behavioral Healthcare

Access. Care. Recovery.

SYSTEM MEMBERSHIP APPLICATION

Please complete (type or print) and return this application form with your dues payment.

System Name: ______________________________

Address: ______________________________

City: ______________ **State:** ______________ **Zip:** ______________

Telephone: ______________ **Fax:** ______________

Website: ______________ **Email:** ______________

Tax status (choose one): Not-for-profit For-profit

Contact person completing this form: ______________________________

Phone/extension: ______________ **Is your system part of a larger entity?** Yes No

If yes, please list name, address, and phone of that entity: ______________________________

____

Please include your membership-dues check with this application.
(To determine your dues, you must complete the net revenue section of this application.)

SYSTEM INFORMATION

Please review the descriptions below and choose only one option that best describes your system.

- ☐ **Multi-facility Organization:** An organization that owns, operates or manages two or more facilities/programs/centers
- ☐ **Specialty Inpatient Hospital:** An organization licensed by the state and operated as a hospital primarily concerned with the provision of inpatient care to persons with mental illness or addiction
- ☐ **General Hospital Psychiatric Unit:** A unit in a general hospital or a facility licensed as part of a general hospital that is solely dedicated to the delivery of mental health and/or substance use disorders
- ☐ **Residential Treatment Center—Mental Health:** An organization licensed to provide overnight mental healthcare in conjunction with an intensive treatment program in a setting other than a hospital
- ☐ **Residential Treatment Center—Substance Use:** An organization licensed to provide overnight substance use care in conjunction with an intensive treatment program in a setting other than a hospital
- ☐ **Partial Hospitalization Program:** A planned program of mental health or substance use treatment services provided to groups of patients with three or more sessions per day

☐ **Intensive Outpatient Program:** A prescribed course of mental health or substance use disorder treatment in which the patient receives outpatient care no fewer than three times a week (this may include more than one service per day)

☐ **Outpatient Center:** An organization providing services outside a hospital setting

☐ **Opioid Treatment Program:** An accredited treatment program with Substance Abuse and Mental Health Services Administration (SAMHSA) certification and Drug Enforcement Administration (DEA) registration to administer and dispense opioid agonist medications that are approved by the Food and Drug Administration (FDA) to treat opioid addiction

☐ **Therapeutic School:** Day programs or 24-hour settings that provide an integrated environment focused on the physical, emotional, behavioral and academic development for youth

☐ **Community Mental Health Center:** A community mental health facility that provides behavioral health services; depending on the facility, these services may include inpatient and outpatient treatment, emergency care, individual and family therapy, support groups, health education, screenings, and psychosocial rehabilitation

Describe levels of care provided and populations served (check all that apply):

Inpatient (hospital)	**Residential**	**Partial hospitalization**	**Outpatient**
☐ Children	☐ Children	☐ Children	☐ Children
☐ Adolescents	☐ Adolescents	☐ Adolescents	☐ Adolescents
☐ Adults	☐ Adults	☐ Adults	☐ Adults
☐ Older adults	☐ Older adults	☐ Older adults	☐ Older adults

Dues are based on the net revenue for all behavioral healthcare components of your system.

All information provided will be kept confidential.

Net Revenue: Gross behavioral healthcare patient care revenue minus contractual allowances, bad debt, charity care, research grants, and endowment revenue.

Timeframe for reporting revenue is the most recent fiscal year.

Reporting period is ______________________________

System Net Revenue: (check only one)

If your system's revenues are	**you pay**	**If your system's revenues are**	**you pay**
☐ Below $7 million	$3,500	☐ $151 million–$200 million	$100,000
☐ $7 million–$9.9 million	$4,500	☐ $201 million–$300 million	$170,000
☐ $10 million–$19.9 million	$6,500	☐ $301 million–$400 million	$220,000
☐ $20 million–$29.9 million	$7,500	☐ $401 million–$500 million	$270,000
☐ $30 million–$39.9 million	$8,500	☐ $501 million–$700 million	$320,000
☐ $40 million–$49.9 million	$10,500	☐ $701 million–$900 million	$370,000
☐ $50 million–$59.9 million	$17,000	☐ $901 million–$1.1 billion	$400,000
☐ $60 million–$99.9 million	$30,000	☐ $1.1 billion–$1.3 billion	$450,000
☐ $100 million–$150 million	$65,000	☐ $1.3 billion	$450,000 + $50,000 per $200 million above $1.3 billion

Please fill in total Net Revenue if it is higher than $1.3 billion: $______________________________

PERSONNEL

1. Please list the names of the key behavioral healthcare leaders within your system so that we may better serve your team.

Position	Full name	Email address

2. Please provide a list of all the facilities you operate.

This list will be used to share our weekly newsletter with the CEOs of all your facilities. Please attach a list providing the following information for each site. COPY THIS FORM TO REPORT ADDITIONAL FACILITIES.

Facility ____________________

Type of facility (check only one)

- ☐ Specialty Inpatient Hospital
- ☐ General Hospital Psychiatric Unit
- ☐ Residential Treatment Center—Mental Health
- ☐ Residential Treatment Center—Substance Use
- ☐ Partial Hospitalization Program
- ☐ Intensive Outpatient Program
- ☐ Outpatient Center
- ☐ Opioid Treatment Program
- ☐ Therapeutic School
- ☐ Community Mental Health Center

Address: ____________________

City: ____________________ **State:** ____________________ **Zip:** ____________________

Telephone: ____________________ **Fax:** ____________________

Website: ____________________ **Email:** ____________________

Facility's Chief Executive Officer

Full name including suffix: ____________________

Email: ____________________

SUBMITTED BY

____________________ (signature)

____________________ (date)

Please return form to:

National Association for Behavioral Healthcare

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