



NJAMHAA

MEMBERSHIP APPLICATION

Thank you for applying for membership in NJAMHAA. We can begin the process of having your membership approved once we receive your completed application, completed dues worksheet, dues payment and a one-page description of your organization. You are welcome to also include a brochure. Please indicate if you need an invoice and then either send a check made out to NJAMHAA or indicate your plans to pay by credit card when you submit the application and dues worksheet. For a credit card payment, you will receive through e-mail a link to a secure web page to process the transaction. Please note that there will be a service charge incurred if you use your credit card.

For new members joining more than halfway into the fiscal year, the initial dues invoice will be for the amount that covers the remaining months of that fiscal year plus the entire following fiscal year. Thereafter, the member will be billed annually in the beginning of each fiscal year at the current annual dues rate.





Staff Person to Receive Membership Dues Invoices



Please read the following statement and sign beneath it:

My organization and I agree to maintain ethical standards in all areas, including marketing.

Signature of Authorized Representative

Date



Branches: (please use a separate sheet, if additional space is needed)

	
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Branches: (continued)

	
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Branches: (continued)

	
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Agency Type:

- | | | |
|--|---|--|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Mental Health Only | <input type="checkbox"/> In Vivo |
| <input type="checkbox"/> Freestanding | <input type="checkbox"/> Emergency Response | <input type="checkbox"/> Residential |
| <input type="checkbox"/> Addictions Only | <input type="checkbox"/> Mobile Response | <input type="checkbox"/> Comprehensive |

Other

Organization is:

☐ Non-Profit

☐ For-Profit

**Did a NJAMHAA member encourage you to apply for membership?
If so, please provide his/her name, organization and contact
information. Thank you.**





Total Budget Size: *(Includes all funds/revenues received for behavioral health and other related services (e.g., including intellectual/developmental disabilities), regardless of the source or the state where the service is provided. Please refer to the Dues Worksheet and indicate the budget size below:*

- | | |
|--|---|
| <input type="checkbox"/> \$0 - \$250,000 | <input type="checkbox"/> \$15,000,001 - \$20,000,00 |
| <input type="checkbox"/> \$250,001 - \$500,000 | <input type="checkbox"/> \$20,000,001 - \$30,000,00 |
| <input type="checkbox"/> \$500,001 - \$1,000,000 | <input type="checkbox"/> \$30,000,001 - \$40,000,00 |
| <input type="checkbox"/> \$1,000,001 - \$2,000,000 | <input type="checkbox"/> \$40,000,001 - \$50,000,00 |
| <input type="checkbox"/> \$2,000,001 - \$3,000,000 | <input type="checkbox"/> \$50,000,001 - \$60,000,00 |
| <input type="checkbox"/> \$3,000,001 - \$4,000,000 | <input type="checkbox"/> \$60,000,001 - \$75,000,00 |
| <input type="checkbox"/> \$4,000,001 - \$5,000,000 | <input type="checkbox"/> \$75,000,001 - \$80,000,00 |
| <input type="checkbox"/> \$5,000,001 - \$6,000,000 | <input type="checkbox"/> \$80,000,001 - \$90,000,00 |
| <input type="checkbox"/> \$6,000,001 - \$7,000,000 | <input type="checkbox"/> \$90,000,001 - \$100,000,00 |
| <input type="checkbox"/> \$7,000,001 - \$8,000,000 | <input type="checkbox"/> \$100,000,001 - \$110,000,00 |
| <input type="checkbox"/> \$8,000,001 - \$9,000,000 | <input type="checkbox"/> \$110,000,001 - \$120,000,00 |
| <input type="checkbox"/> \$9,000,001 - \$10,000,000 | <input type="checkbox"/> \$120,000,001 - \$130,000,00 |
| <input type="checkbox"/> \$10,000,001 - \$11,000,000 | <input type="checkbox"/> \$130,000,001 - \$150,000,00 |
| <input type="checkbox"/> \$11,000,001 - \$12,000,000 | <input type="checkbox"/> \$150,000,001 - \$175,000,00 |
| <input type="checkbox"/> \$12,000,001 - \$13,000,000 | <input type="checkbox"/> \$175,000,001 and over |
| <input type="checkbox"/> \$13,000,001 - \$14,000,000 | |
| <input type="checkbox"/> \$14,000,001 - \$15,000,000 | |



**Does the organization have contracts
with the State of New Jersey?**
(Please check all that apply.)

- ☐ **Department of Children and Families**
 - ☐ **Division of Child Protection and Permanency**
 - ☐ **Division of Children's System of Care**
 - ☐ **Division of Family and Community Partnerships**
 - ☐ **Division on Women**
- ☐ **Department of Community Affairs**
- ☐ **Department of Corrections**
- ☐ **Department of Education**
- ☐ **Department of Health**
- ☐ **Department of Human Services**
 - ☐ **Division of Aging Services**
 - ☐ **Division of Developmental Disabilities**
 - ☐ **Division of Family Development**
 - ☐ **Division of Medical Assistance and Health Services**
 - ☐ **Division of Mental Health and Addiction Services**
- ☐ **Department of Labor**
- ☐ **Other**

**Is the organization licensed
by any of the following?**
(Please check all that apply.)

- ☐ **Department of Children and Families**
 - ☐ **Division of Child Protection and Permanency**
 - ☐ **Division of Children's System of Care**
 - ☐ **Division of Family and Community Partnerships**
 - ☐ **Division on Women**
- ☐ **Department of Community Affairs**
- ☐ **Department of Corrections**
- ☐ **Department of Education**
- ☐ **Department of Health**
- ☐ **Department of Human Services**
 - ☐ **Division of Aging Services**
 - ☐ **Division of Developmental Disabilities**
 - ☐ **Division of Family Development**
 - ☐ **Division of Medical Assistance and Health Services**
 - ☐ **Division of Mental Health and Addiction Services**
- ☐ **Department of Labor**
- ☐ **Other**



Is the agency part of a larger organization (e.g., health system)? If so, give the larger organization's name and describe the relationship between the larger and smaller organizations (e.g., subsidiary):

Date of incorporation of your agency:

Is there a Board of Directors/Trustees:
(If yes, please attach a list of members.)

- ☐ Yes
☐ No

Does the Board serve in a policy making role or an advisory role?

Has your organization ever been convicted of Medicaid/Medicare abuse or fraud?

- ☐ Yes
☐ No

If Yes, please explain

Have you or any of your key officers/board members been disbarred from professional practice?

- ☐ Yes
☐ No

If Yes, please explain



Describe your agency's purpose as stated in its bylaws:

Towns or counties served:

Please list 3 references:

How did you hear about NJAMHAA?

Accreditations: (e.g., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation, National Committee for Quality Assurance, Det Norske Veritas Inc.'s National Integrated Accreditation for Healthcare Organizations):

Thank you for applying for membership. We look forward to receiving your completed application along with your completed dues worksheet, payment and one-page description of your organization. You may also provide a brochure. If you have any questions, please contact Shauna Moses at 609-838-5488, ext. 204, or smoses@njamhaa.org.

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