Alliance for the Betterment of Citizens with Disabilities

Empowering People: Providers Shaping Policies

127 Route 206, Suite 26, Hamilton, New Jersey 08610 Phone: 609-581-8375 Fax: 609-581-8512
Email: Admin@abcdnj.org

Application for Full Membership

The Alliance for the Betterment of Citizens with Disabilities (ABCD) thanks you for your interest in joining us in our mission. We strive to provide our members with the highest quality service. We look forward to working with your agency.

Agency Contact Information		
Name of Organization:		**Date:**
Executive Director:		
Address:		
City:	**State:**	**Zip:**
Telephone:	**Telephone #2:**	
Fax:	**Email:**	

ABCD Member Sponsorship
Agencies applying for membership must be sponsored by 3 current ABCD member agencies
Sponsoring Organizations: **1.** **2.** **3.**
Member Representatives: **1.** **2.** **3.**

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Agency Operating Information		
Operating Budget: (To be used in establishing dues structure – based on most recent Fiscal Year Audit Report available) *		
Do you have 501c(3) status?	**When was 501c (3) status obtained?**	
Does your organization have accreditation or approval by an organization such as CARF, JCAHO, or the Council on Quality Leadership? **____Yes or ____No**		
If yes, please state which one:		
Please list accredited or approved programs and related information below:		
Program	**Approving Agency**	**Approval Date**
1.		
2.		
3.		
4.		
5.		
If no, are you in the process of obtaining accreditation? Please Explain.		

* For Full Membership Organizations, annual dues are $10,000 minimum cap, $40,000 maximum cap, $35,000 for agencies with total operating budget between $30M-$47M, 0.12% of revenue for agencies operating between $21M-$29M, 0.15% of revenue for agencies operating between $11M-20M, and 0.18% of revenue for agencies with total operating budget between $5M-10M.

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Agency Service Information	
Primary Programming Areas	
1.	**2.**
3.	**4.**
Please List Program Below	**Disabilities of Individuals Served:**
1.	
2.	
3.	
4.	
5.	
Please describe the functional needs of the individuals whom you serve:	

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ABCD — Full Membership Organization Agreement:

ABCD's Mission

The mission of ABCD, an association of social service agencies, is to affect the development and implementation of public policy and to support the member organizations whose specific purpose is to improve the lives of people with complex physical and developmental disabilities so that they can achieve the highest level of purpose and dignity.

1. **Does your agency actively support the Mission of ABCD?** **Yes** **No**
2. **Responsibilities of Membership** ***(please initial after each responsibility)***

ABCD membership is open to all social service agencies operating in New Jersey. ABCD full members may expect all of the benefits of membership in ABCD as a whole.

- All ABCD Member Organizations agree to actively provide mutual assistance to one another and the ABCD staff. Examples of mutual assistance include but are not limited to data collection for ABCD's policy and advocacy efforts, sharing of policies, and sharing of information and resources. The identity of the agency providing the mutual assistance will be confidential to ABCD's Executive Director, unless otherwise stipulated by the agency.

_____

- Each Member Organization will designate a senior staff person, preferably the Executive Director, to represent the Member Organization in ABCD activities including attendance at board, annual, special, and committee meetings.

_____

- Each Member Organization will also designate a senior staff person to represent the Member Organization at forums and training opportunities provided by ABCD.

_____

- All Member Organizations will provide input and information to ABCD on a routine and emergent basis including, {1) key topics and issues, {2) service needs within their geographic confines, and {3) areas which directly or indirectly impact Member Organizations, or the individuals with disabilities and their families served by the Members.

_____

As the Executive Director of _____, I am applying to become a full member of ABCD. In doing so, I make full assurances that _____is committed to the ABCD Mission. I understand that the dues calculation is based on a full fiscal year (July 1 to June 30). Dues remain the obligation of the member agency and are non-refundable. We pledge to make our dues payments in a timely manner based on the identified payment schedule. I also recognize _____ as our agency's DD Alliance Representative and I assure that she/he will uphold the membership responsibilities outlined above.

_____ _____

Signature ***Date***

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Return this Application by e-mail to Cathy Chin, Executive Director:

ABCD
127 Route 206, Suite 26
Hamilton, NJ 08610

E-mail: Admin@abcdnj.org