



APPLICATION FOR MEMBERSHIP

The Developmental Disabilities Alliance of Western New York is a collaborative group of member voluntary agencies that provide services to people with developmental disabilities. While honoring individual agency missions, it is the intent of the Alliance to assist agencies to develop relationships, promote unified strategies and share risks for the mutual gain with and for the benefit of people with developmental disabilities.

Submission of your application constitutes your acceptance of the rules as stated in the enclosed "By-Laws of the Developmental Disabilities Alliance of Western New York" and of the basic principles enunciated in the above mission statement.

ORGANIZATIONAL INFORMATION

A. Full corporate name: _____

B. Program name(s) by which you may also be known: _____

C. Administrative address: _____

D. Telephone: _____ Fax: _____
E-mail: _____

E. Chief Executive Officer: _____
Title: _____

F. Proposed Representative: _____
Title: _____

G. How did you hear about DDAWNY? _____

II. PROGRAM INFORMATION

A. Are all legally required government certifications/filings current and in good standing?

___ Yes ___ No (please explain on reverse)

B. Please list accreditations/special licenses, etc. if any. (type, source, date received)

III. HISTORY AND GENERAL BACKGROUND INFORMATION

A. Year organization was founded: _____

B. Are you a not-for-profit corporation? ___ Yes ___ No

B. Site the document in which the purpose of the agency is formally stated (Certificate of Incorporation, Constitution, Charter or other) and quote the purpose as stated.

IV. SCOPE OF OPERATION

Include only existing sites and those for which a title/lease has been secured and completion is certain.

A. Sites of operation: _____

B. Number of clients served: _____

C. Counties served: _____

D. Type(s) of services provided:

| | |
|------------------------------|----------------------------------|
| Early Intervention _____ | Day/Res. Habilitation _____ |
| Preschool Special Ed. _____ | Adult Residential _____ |
| Special Education 5-21 _____ | Article 16 Clinic _____ |
| Children's Residential _____ | Article 28 Clinic _____ |
| Adult Day Treatment _____ | Case Management _____ |
| Sheltered Workshop _____ | F.F.S. Respite _____ |
| Supported Employment _____ | F.F.S. Crisis Intervention _____ |
| Other (please specify) _____ | |

E. Number of staff (FTE): _____

F. Overall agency budget: _____

G. Agency budget devoted to DD Programs (if you are not exclusively a DD provider) _____

V. ADDITIONAL QUESTIONS

A. Why are you interested in a DDAWNY membership for your agency? _____

B. In what ways do you believe your agency can contribute to the strength and collaborative nature of the Alliance?

VI. AUTHORIZATION OF CHIEF EXECUTIVE OFFICER

I have received and reviewed the Developmental Disabilities Alliance of Western New York's By-Laws and Mission Statement included in this application and hereby submit an application for membership.

Signed: _____ Date: _____

