National Association
for Behavioral Healthcare
Access. Care. Recovery.

SYSTEM MEMBERSHIP
APPLICATION

Please complete and return this application form with your dues payment. To determine your dues, you must complete the net revenue section of this application.

System Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____

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

Contact person completing this form: _____

Phone/extension: _____ **Email:** _____

Is your system part of a larger entity? Yes No

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

_____

SYSTEM INFORMATION

Please review the descriptions below and choose all that describe your system and the patient populations you serve.

	Children	Adolescents	Adults	Older Adults
☐ **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	☐	☐	☐	☐
☐ **Office-Based Opioid Treatment:** An Office Based Opioid Treatment (OBOT) allows primary care or general healthcare prescribers with a DATA waiver to dispense or prescribe any Controlled Substances Act (CSA) schedules III, IV, V medication approved by the FDA for the treatment of opioid use disorder	☐	☐	☐	☐

☐ **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 ☐ ☐ ☐ ☐

☐ **Community Based Behavioral Health Center:** A clinic certified by states in accordance with SAMHSA criteria and the requirements of the Protecting Access to Medicare Act of 2014 ☐ ☐ ☐ ☐

☐ **Crisis Stabilization:** Crisis Stabilization Centers provide suicide prevention services, address behavioral health treatment, divert individuals from entering a higher level of care, and address the distress experienced by individuals in a behavioral health crisis ☐ ☐ ☐ ☐

☐ **Recovery Support Services**: Recovery Support Services means a broad range of non-clinical services that assist individuals and families to initiate, stabilize, and maintain long-term recovery, such as but not limited to peer support, supportive employment, and mutual aid groups ☐ ☐ ☐ ☐

☐ **Telehealth:** Telehealth, sometimes called telemedicine, is the use of electronic information and telecommunication technologies to provide care when the patient and provider are not in the same place at the same time ☐ ☐ ☐ ☐

Please add the number of beds, treatment slots, employees, and patients this system serves.

_____ Number of Inpatient Residential Beds

_____ Number of Employees

_____ Number of Outpatient Treatment Slots

_____ Number of Patients Served Each Year

Please select your payor mix from the following categories by percentage.

_____ Medicare

_____ Medicaid

_____ Private Insurance

_____ State or County Funding

_____ Self-pay

_____ Charity care/scholarship

_____ Federal Military Insurance (e.g., TRICARE)

_____ **Total** *(This must total 100%)*

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
☐ Below $7 million	$3,500
☐ $7 million–$9.9 million	$4,500
☐ $10 million–$19.9 million	$6,500
☐ $20 million–$29.9 million	$7,500
☐ $30 million–$39.9 million	$8,500
☐ $40 million–$49.9 million	$10,500
☐ $50 million–$59.9 million	$17,000
☐ $60 million–$99.9 million	$30,000
☐ $100 million–$150 million	$65,000
☐ $151 million–$200 million	$100,000
☐ $201 million–$300 million	$170,000
☐ $301 million–$400 million	$220,000
☐ $401 million–$500 million	$270,000
☐ $501 million–$700 million	$320,000
☐ $701 million–$900 million	$370,000
☐ $901 million–$1.1 billion	$400,000
☐ $1.1 billion–$1.3 billion	$450,000
☐ $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 including suffix	Email address
Chief Executive Officer		
Chief Financial Officer		
Clinical Director		
Government Relations Contact		
Quality and Compliance Director		

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 all that apply)*

- ☐ 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
- ☐ Office-Based Opioid Treatment
- ☐ Therapeutic School
- ☐ Community Mental Health Center
- ☐ Community Based Behavioral Health Center
- ☐ Crisis Stabilization
- ☐ Recovery Support Services
- ☐ Telehealth

_____ Number of Inpatient Residential Beds

_____ Number of Employees

_____ Number of Outpatient Treatment Slots

_____ Number of Patients Served Each Year

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____

Website: _____

Facility's Chief Executive Officer

Full name including suffix: _____

Email: _____

SUBMITTED BY

_____ _____

(signature) (date)

Please return form to:

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