APPLICATION FOR AFFILIATE MEMBERSHIP

FOR THE MEMBERSHIP YEAR: 10/1/2025 - 9/30/2026

The Ohio Council
Of Behavioral Health & Family Services Providers

Company:

Address:

City/State/Zip:

Phone:

Email:

Website:

Company Representative - This person will be listed as the main contact in the directory and will receive all email notices.

Name: **Title:**

Phone: **Email:**

Description of Company Product/Service - Please limit to 150 words or less:

Affiliate Membership in the Ohio Council is $3,000 per annual membership year, 10/1/2025 - 9/30/2026

Please indicate your method of payment:

☐ **Check Enclosed**

☐ **Send Invoice**

Authorized Signature: **Date:**

Please complete this application and return to:

The Ohio Council of Behavioral Health & Family Service Providers
17 S. High Street, Suite 799, Columbus, OH 43215
or email to cowan@theohiocouncil.org