BEACH Partnership Continuum of Care Membership Application

Please Choose One: Date: _____

- Membership Information Update
- New Membership

Agency Name: _____

Street Address: _____City, State, Zip_____

Mailing Address:_____ City, State, Zip_____

Telephone Number: _____ Fax Number _____

Agency Web Address: _____

Is your agency a 501©(3) non-profit status? Yes No Pending

Government Entity: Yes No Faith Based: Yes No

Executive Director/Director's Name & Phone: _____

Email Address: _____

Who is authorized to vote in the CoC on behalf of your agency?

Representative Name/Phone: _____

Representative Email: _____

Alternate #1 Name & Email: _____

Alternate # 2 Name & Email: _____

Population Served: (check all that apply)

○ Single Male	○ Homeless
○ Single Female	○ Chronically Homeless
○ Families	○ HIV/AIDS
○ Women w/ children	○ Substance Abuse
○ Domestic Violence	○ Mental Illness
○ Veterans	○ Developmentally Delayed
○ Adolescents	○ Disabled
○ Chronically Homeless	○ Other (specify)

Program Type (s)_____

Brief Program Description: _____

Admission/Eligibility Criteria: _____

Referral Process: _____

Hours/Days of Operation: _____

Additional Information: _____

_____

I acknowledge that for the above agency to be considered an active BEACH Partnership CoC member, agency delegates) at least one delegate being in the executive or managerial position) must meet the CoC By-Laws definition of active membership under Article III Section II (c) .

_____

Signature Date