Treatment Communities of America

Regular Membership Application

All prospective members of TCA are required to complete this registration form.

☐ **NEW MEMBERSHIP** ☐ **RENEWAL**

SECTION I: MEMBER CONTACT INFORMATION

AGENCY:			
NAME	☐Mr ☐Mrs ☐Miss ☐Ms		
ADDRESS 1		**MAIN TELEPHONE**	
ADDRESS 2		**WORK TELEPHONE (if**	
ADDRESS 3		**HOME TELEPHONE**	
TOWN/CITY		**MOBILE PHONE**	
ZIP CODE		**PRIMARY EMAIL**	
JOB TITLE:		**SECONDARY EMAIL**	

***Star the e-mail and phone number you would like listed in the directory**

SECTION II: AGENCY CATEGORY

AGENCY TYPE	SELECT CATEGORY
Private, non-profit	
State/County Agency	
Private, for-profit	
Other:	

SECTION III: AGENCY'S AUTHORIZED REPRESENATIVES

CHIEF EXECUTIVE OFFICER		
Name:		
Address:		**Phone:**
City:	**State:**	**ZIP Code:**
Email:		
OTHER AUTHORIZED REPRESENATIVE		

Name:		
Address:		**Phone:**
City:	**State:**	**ZIP Code:**
Title:		
Email:		

SECTION IV: AGENCY INFORMATION

What year was your agency founded? _____

Please indicate all services provided by your agency and the capacities of each service modality:

Service Modality	Slots	No. Of Clients	Average Length of Program
Hospital Inpatient			
Partial/Day Hospital			
Residential Rehab (non-TC)			
Residential TC			
Prison TC			
Day TC			
Outpatient			
Medication Assisted Treatment			
Prevention			
Other:			

Please indicate all populations served by your agency's Special Programs:

Population	Modality	No. of Slots
Men Only		
Women Only		
Mixed Gender		
Adolescents		
Women w/Children		
Men w/Children		
Pregnant Women		
Non-English Program		
MICA		
Co-Occurring		
HIV		

Aging		
Homeless		

If your agency provides services at more than one location, please list the names and locations of your programs below:

Name of Program	Location (Street Address, City, State, and Zip Code)

If the applicant agency is owned by another corporate entity, please provide the corporation name and address, as well as the name, phone number, and email of the Chief Executive Officer:

Company Name:		
Address:		**Phone:**
City:	**State:**	**ZIP Code:**
Chief Executive Officer:		
CEO's Email:		

SECTION V: BUDGETARY INFORMATION

Please identify the highest operational entity within the corporate structure whose primary purpose is drug and alcohol services, and check the category reflecting that entity's total annual operating budget:

Check Here	Total Agency Budget	Dues
	Up to $1,499,99	**$630**
	$1.5 million to $2,799,999	**$1,265**
	$2.8 million to $4,499,999	**$2,534**
	$4.5 million to $7,499,999	**$3,798**
	$7.5 million to $13,999,999	**$5,171**

	$14 million to $19,999,999	**$6,337**
	$20 million to $29,999,999	**$7,607**
	$30 million to $39,999,999	**$8,875**
	$40 million and above	**$10,143**

SECTION VI: REFERENCES

Please provide the names and contact information for three (3) individuals who are in a position to attest that your agency operates a treatment program that meets, or exceeds, statutory regulations.

The provided references will be contacted by the Chairman of the TCA Membership Committee. Your agency's references may also submit a letter of recommendation to TCA.

It is preferable that at least one reference be a current or former member of TCA.

REFERENCE #1		
Name:		
Address:		**Phone:**
City:	**State:**	**ZIP Code:**
Company:		
Title:		
Email:		

REFERENCE #2		
Name:		
Address:		**Phone:**
City:	**State:**	**ZIP Code:**
Company:		
Title:		

Email:

REFERENCE #3		
Name:		
Address:		**Phone:**
City:	**State:**	**ZIP Code:**
Company:		
Title:		
Email:		

SECTION VII: SUBMITTING YOUR APPLICATION

Certification:

Please submit a copy of all applicable licenses and/or certification papers for your organization.

Assurances

The applicant agency hereby assures that:

1. It provides services to those who suffer from a substance use disorder and/or people with behavioral or emotional problems and their families;

2. It agrees to abide by the TCA By-Laws, Code of Ethics and Member Rules as may be adopted by TCA Membership; and

3. Its Treatment program(s) is (are) appropriately licensed/certified/approved by proper authorities as required by statute and as evidenced by enclosed documents, or is waived from such requirements as justified herein in writing.

Please submit your completed application with your check for membership dues to:

Treatment Communities of America
409 7th Street, NW, Suite 450
Washington, DC 20004

Please contact Pat Clay, Executive Director at pat@treatmentcommunities.com, if you have any questions about membership.

SECTION VIII: SIGNATURES

SIGNATURES	
I authorize the verification of the information provided on this form.	
Signature of CEO:	Date: