

# Membership Application



**Date of Application:** \_\_\_\_ / \_\_\_\_ /2020

- New member
- Renewal

Member Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ +4 \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

Employer \_\_\_\_\_

Is your employer a Matching Funds Company? \_\_\_\_\_

## Person with Developmental Disability

Name \_\_\_\_\_ Male / Female *(Circle One)*

Birthdate \_\_\_\_\_ Type of Disability \_\_\_\_\_

Is this person receiving a Medicaid Waiver service? Yes/No *(Circle One)* If so, what?

\_\_\_\_\_

Is this person currently on the waiting list for a waiver? Yes / No *(Circle One)*

## Membership Dues

- \$25.00 Family
- \$25.00 Volunteer/Advocate
- \$40 Mental Health Professional / Education Professional
- \$100 Elected Official
- \$150 Small Business/Church/Civic Group
- \$250 Corporate Sponsorship/Board Member
- \$ \_\_\_\_\_ Additional donation to Special Needs Cobb

(In Honor or Memory of: \_\_\_\_\_)

## Payment Options

- Mail a check payable to Special Needs Cobb to:*  
1830 Water Place, Suite 120, Atlanta (Cobb County), Georgia 30339