Membership Application

Special Needs Cobb
Resources. Respite. Residential.

Date of Application: _____/_____/_____

- ❑ 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