



For more information, contact:

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Or visit our website: SCCCMH-Saratoga.org and check out our Facebook Page!

### **ANNUAL MEMBERSHIP REGISTRATION FORM**

*Revolving Membership for one year from the date you join SCCCMH*

**SCCCMH Mission:** SCCCMH is a non-profit, charitable organization [501(c)3] whose mission it is to: Program Development and Enrichment: Award grants of approximately \$1000 to agencies and programs in Saratoga County that provide services to people with mental illness or have mental and emotional needs so they can enrich existing programs or expand services.

**Education:** Provide affordable educational opportunities for mental health professionals and consumers of mental health services.

**Advocacy:** Advocate for improved mental health care and services by lobbying government and elected officials.

**Increase Awareness:** Increase public awareness of the needs of individuals with mental illness. For example, increase access to public transportation, decrease stigmas or stereotypes.

**Member Benefits:** Membership fees support the development of mental health services in Saratoga County through grants, educational opportunities, and lobbying, as well as the publication of the biannual SCCCMH Newsletter.

## **More Members. More Power. More Benefits.**

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#### **PLEASE CHECK ONE:**

New Member     Membership Renewal     Remove my information from SCCCMH mailing

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Prefix/Suffix: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If you want to receive the newsletter and other notices from SCCCMH, please provide your e-mail address:

Email Address: \_\_\_\_\_

If you are a provider of mental health services and would like to be included in the Saratoga County Network for Mental Health Professionals and Advocates (SCN-MHPA), then check here:

If you would like to participate in a mental health consumer workshop, then check here:

#### **Membership fee is based on a "pay what you will" basis (Check One):**

I want to be a member, but I am unable provide financial support.

I want to be a member. I will consider a contribution at a later date.

I want to be a member, enclosed is my tax deductible donation of:  \$10  \$25  \$35 Other: \_\_\_\_\_

**MAKE CHECKS OUT TO:** SCCCMH. Please do not send cash in the mail.

**MAIL TO:** SCCCMH, P.O. Box 820, Saratoga Springs, New York 12866

**MAKE SURE THE VOICE OF THE SARATOGA COUNTY MENTAL HEALTH COMMUNITY IS HEARD...JOIN SCCCMH TODAY!!**