# Southern Illinois Continuum of Care Network

**"working to make a difference"**

**ANNUAL MEMBERSHIP INVOICE (Revised 11/2/2017)**

(Membership is January – December)

***Please print carefully:***

What year of membership are you covering with this payment? **20_____**

**INDIVIDUAL MEMBERSHIP INFORMATION…….$25.00 Annual Membership Dues**

Member Name (if individual membership): _____

Email Address: _____ Phone Number: ( _____ ) _____ - _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

**AGENCY MEMBERSHIP INFORMATION…….$125.00 Annual Membership Dues**

Business Name: _____

Business Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Please list all agency staff you wish to have on the continuum contact list:

| Staff Name(s) | Phone Number | Email Address |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

***I designate the staff below to have full voting rights for our agency at continuum meetings. If the primary designee is not available, the alternate designee may vote in their absence on behalf of our agency.***

Primary Designee's Name: _____

Alternate Designee's Name: _____

Agency CEO Signature: _____ Date: _____

**Please remit check and this invoice to:**
Southern Illinois Continuum of Care
C/O Family Crisis Center
Attn: Peggy Russell
PO Box 2066
Herrin, IL 62948-5266

**Checks payable to:**
Southern Illinois Continuum of Care

**Treasurer's Use Only**

Date Paid: _____
Check #: _____
Initial: _____

Date sent
to co-chairs: _____