



APPLICATION/RENEWAL MEMBERSHIP FORM

For the year 1 July 2016 – 30 June 2017

1. Contact Information

Name of Organisation:		New Member <input type="checkbox"/>	Existing Member <input type="checkbox"/>
Address:	City:	Post Code:	Telephone:
Mailing Address (if different)			
Contact person for membership:		Email address:	
Add other emails to receive e-newsletters			
Additional email 1: _____		Additional email 2: _____	
Name and job title : _____		Name and job title: _____	

2. Legal Information

Charities Registration Number:			
Level of approval:	<input type="checkbox"/> Section 396 – Level 1 <input type="checkbox"/> Section 403 – Level 2 <input type="checkbox"/> Section 403 – Level 3 <input type="checkbox"/> Level 4 <input type="checkbox"/> Level 5	Evidence of contract: Please provide either	
		<input type="checkbox"/> Copy of the front page of your MSD contract (with Contract Number) or <input type="checkbox"/> Copy of your agreement	
Legal Status:	<input type="checkbox"/> Incorporated Society <input type="checkbox"/> Charitable Trust <input type="checkbox"/> Other: _____	Contract year end:	
		<input type="checkbox"/> 2016 <input type="checkbox"/> 2017 <input type="checkbox"/> 2018 <input type="checkbox"/> 2019	

3. Service Information

MSD Agreements: List your contracted services or programmes (e.g. Care & Permanency Services)	
Non-MSD Contracts: List any contracted services or programmes (e.g. MOJ: safety services for domestic violence victims)	

4. Operational Information

Years of operation:	<input type="checkbox"/> 0-4 years	<input type="checkbox"/> 5-10 years	<input type="checkbox"/> 10+ years
Geographic Reach:	<input type="checkbox"/> Local	<input type="checkbox"/> Regional	<input type="checkbox"/> National
Annual Budget and Funders:	<input type="checkbox"/>		

	MSD \$ _____ <input type="checkbox"/> MOJ \$ _____ <input type="checkbox"/> DHB \$ _____ <input type="checkbox"/> Other: _____ \$ _____ _____ \$ _____
Does your organisation have a cultural or ethnic focus?	No - <input type="checkbox"/> Available to all Yes - <input type="checkbox"/> Maori <input type="checkbox"/> Pakeha/ European <input type="checkbox"/> Pacific <input type="checkbox"/> Refugee/Migrant <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____
Number of staff:	Staff _____ number Volunteers _____ _____ FTE
Number of clients in previous year :	<input type="checkbox"/> Individual (child, clients, parents) Number _____ <input type="checkbox"/> Group (family) Number _____ <input type="checkbox"/> Agency/Organisation Number _____

**5. What benefits do you want from SSPA Membership?
(e.g. regional networks, advocacy, information)**

6. Membership Options (GST inclusive): Please choose one of the following options.

Member Organisation's Budget	Annual SSPA Membership Fee	
Under \$250,000	\$50.00	<input type="radio"/>
\$250,000 - \$1,000,000	\$75.00	<input type="radio"/>
Over \$1,000,000	\$100.00	<input type="radio"/>

Total you are paying: \$ _____

Do you require a Tax Invoice? Yes / No

Do you require a receipt? Yes / No

Direct Debit: BNZ 02-0191-0193879-00; Account Name: Social Service Providers Aotearoa Inc.

Signature: _____