



Southern Illinois Continuum of Care Network

“working to make a difference”

ANNUAL MEMBERSHIP INVOICE (Revised 11/1/2019)

(Membership is January – December)

Please print carefully:

What year of membership are you covering with this payment? 2020__

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>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.</i>		
Primary Designee’s Name: _____		
Alternate Designee’s Name: _____		
Agency CEO Signature: _____		Date: _____

Please remit check and this invoice to:

Southern Illinois Continuum of Care
Attn: Peggy Russell
PO Box 2066
Herrin IL 62948-5266

Treasurer’s Use Only

Check Date:	_____
Check #:	_____
Date Received:	_____
Initial:	_____
Date sent to co-chairs:	_____