HOMELESS COALITION of Southern Indiana

Affiliate Membership Form

Member Information (please print or type)

Name _____

Address _____

City, ST Zip Code _____

Contact Person _____

Phone 1 | Phone 2 _____

Fax | Email _____

Website URL: _____

Type of Agency or Program

☐Service Agency ☐Food Pantry ☐Soup Kitchen ☐Homeless Shelter

☐Other: _____

_____

Please briefly describe your program:

_____

_____

_____

_____

_____

_____

_____

Please briefly describe your services or contact with the homeless or at-risk population:

Type of membership desired:

☐Community Partner

☐Referral Agency or Program

☐Friends of the Coalition and wish to attend meetings

☐Informational only

Please note that any agency wishing to receive referrals for service and wish to be part of centralized intake will be required to submit a program audit. This will include a building audit for health and safety as well as a general audit for services.

Stay Connected. Please provide names and emails of individuals who would like to receive email communication from HCSI.

Name | Email

Name | Email

Name | Email

Name | Email

Name | Email

Name | Email

Name | Email

Member Representative Signature(s) *Date*

Please make membership investment payable to:

Homeless Coalition of Southern Indiana
P.O. Box 1871
New Albany, IN 47151