WI Balance of State Continuum of Care
Membership Application

Thank you for expressing an interest in becoming a member of the Wisconsin Balance of State Continuum of Care (WIBOSCOC). Member applicants must demonstrate that the Local Coalition (LC) meets the qualifications set forth in Article II, Section 1 of the WIBOSCOC Bylaws and that the members of the Local Coalition have voted to apply for Membership in the WIBOSCOC.

Please complete and submit the completed Membership Application to wiboscoc@gmail.com at least 90 days prior to the next scheduled meeting of the Members. To see a list of meeting dates please visit https://www.wiboscoc.org/quarterly-meetings.html.

General Information Section

To be considered a member of the WIBOSCOC, please fill in the information below accurately and completely. The information in this packet will be reviewed by the current Board of Directors and the process for membership consideration will be followed.

Local Coalition Name: _____

Local Coalition County(ies): _____

Local Coalition Contact Information

Name: _____
(First) (Middle) (Last)

Work Phone: _____ Cell Phone: _____

Email Address: _____

Eligibility Assurances:

The Coalition

Represents a defined geographic area within the WIBOSCOC geographic service area that does not overlap an area served by another Local Coalition	☐YES ☐NO
Includes representation from both the private and nonprofit sectors of our community, including individuals who are experiencing homelessness or who were formerly homeless;	
Will adopt a memorandum of understanding, corporate charter, or other written document(s) acceptable to the WIBOSCOC ("Governance Documents") which will describe the Local Coalition's rights and responsibilities as a Member of the WIBOSCOC, the process the Local Coalition will follow to select and remove its Delegate for Membership meetings, the period of time its Delegate will serve in that capacity, the Delegate's responsibilities to the Local Coalition and the process for appointment of a Board of Director.	☐YES ☐NO
Will meet at least four times per calendar year	☐YES ☐NO
Will have sent a representative to at least two meetings of the WIBOSCOC Members or Board of Directors within the prior calendar year.	☐YES ☐NO

Local Coalition Information Section

In the space below, please describe the historical timeline of your Local Coalition.

Please list the Local Coalition Membership.

Please explain your Local Coalition's interest in becoming a member of the WIBOSCOC.

Please list any Local Coalition members that have current funding sources specifically for people at risk of homelessness or experiencing homelessness and describe those sources.

What strengths does your Local Coalition have that will assist the WIBOSCOC end homelessness?

WIBOSCOC

Additional Information

Describe any unique characteristics of your Local Coalition or any additional information you feel may be helpful to us in considering your application.

I certify that all the information provided by me in this application (or any other accompanying or required documents) is correct, accurate and complete to the best of my knowledge. I understand that submission of this packet does not guarantee membership acceptance to the WIBOSCOC.

_____
Please Print Name

_____ _____
Signature Date

Thank you for your interest in WIBOSCOC. Please email the completed packet to: wiboscoc@gmail.com and the current WIBOSCOC Board secretary.