



North Carolina Providers Council
Bob Hedrick, MAEd, Executive Director
4700 Homewood Court, Suite 320 • Raleigh, NC 27609
Phone: 919-784-0230 • Fax: 919-784-0231
www.ncproviderscouncil.org

NEW MEMBERSHIP APPLICATION

Date of Application: _____ Referred By: _____

Part I

Agency/ Provider Name*:
Parent/Management Entity*:
Corporate Mailing Address:
Owner/CEO/President:

*Current multi-corporation members, or members acquired by other member agencies, can choose to: 1) Keep separate memberships as currently done for each corporation based on revenues for each corporation, including benefits and voting privileges for each corporation; or 2) Have one membership for multi-corporations under one management company based on total revenues for all agencies owned/managed by the parent company.

Part II

Services Provided - Please indicate the number of people supported with the following disabilities:

Total # of people with development disabilities:	Child: _____	Adult: _____
Total # of people with mental illness:	Child: _____	Adult: _____
Total # of people with substance abuse/addictive disease:	Child: _____	Adult: _____

How many people identified above are served in their:

Natural Home: _____ Other Paid Residential Options: _____

To assist the NC Providers Council with representing providers at the NC General Assembly and DHHS, please indicate the following (*will be used only in a cumulative way with all members*):

Total No. of Employees: _____

List all NC counties in which you provide services:

Please list all accreditations (local or national) that your agency currently holds:

Part IV

Agency Contact Information for Membership:

(Note: if your agency is applying for the Executive Membership, skip this Part IV and go to Part V)

1) **Voting Member Name:** _____ Phone/Ext.: _____

Title: _____ Fax: _____

Mailing Address: _____

City/State/Zip: _____

Email: _____ Website: _____

(The agency can identify three additional employees to receive email communications from the NC Providers Council membership listserv in addition to the voting member.)

2) Name: _____

Title: _____ Email: _____

3) Name: _____

Title: _____ Email: _____

4) Name: _____

Title: _____ Email: _____

Part V

Agency Contact Information for Executive Membership:

1) Voting Member Name: _____ Phone/Ext.: _____

Title: _____ Fax: _____

Mailing Address: _____

City/State/Zip: _____

Email: _____ Website: _____

Employees to Receive Membership Listserv Emails:

The agency may identify 9-21 additional email addresses depending on their dues level (see dues structure chart on page 2 that includes number of email addresses available for your level) in addition to the voting member.

2) Name: _____ Email: _____

Title: _____

3) Name: _____ Email: _____

Title: _____

4) Name: _____ Email: _____

Title: _____

5) Name: _____ Email: _____

Title: _____

6) Name: _____ Email: _____

Title: _____

7) Name: _____ Email: _____

Title: _____

8) Name: _____ Email: _____

Title: _____

9) Name: _____ Email: _____

Title: _____

10) Name: _____ Email: _____

Title: _____

11) Name: _____ Email: _____

Title: _____

12) Name: _____ Email: _____

Title: _____

13) Name: _____ Email: _____

Title: _____

14) Name: _____ Email: _____

Title: _____

15) Name: _____ Email: _____

Title: _____

16) Name: _____ Email: _____

Title: _____

17) Name: _____ Email: _____

Title: _____

18) Name: _____ Email: _____

Title: _____

19) Name: _____ Email: _____

Title: _____

20) Name: _____ Email: _____

Title: _____

21) Name: _____ Email: _____

Title: _____

22) Name: _____ Email: _____

Title: _____

The Signature of the Owner, CEO, or President is required below:

I have read and I understand the NC Providers Council's Code of Ethics and agree to abide by them and the responsibilities they require and imply. I certify that the information I have provided accurately represents the agency and that any false information will be grounds for rejection of my application or termination of our NC Providers Council membership.

Signature: _____ **Printed Name:** _____

Phone/Ext.: _____

Title: _____ Fax: _____

Mailing Address: _____

City/State/Zip: _____

Email: _____ Website: _____

Application must be filled out completely. Incomplete applications cannot be processed. Please enclose your check payable to NC Providers Council and return to:

**NC Providers Council
Diana Mills, Office Administrator
4700 Homewood Court, Suite 320
Raleigh, NC 27609**

If you have any questions concerning membership, please contact the Raleigh office at (919) 784-0230 or email diana.mills@ncproviderscouncil.org or donna.gonyeau@ncproviderscouncil.org.

For Internal Use Only	
Date Received	
Date to Board	
Date to Membership	
Date Approved	
Check #	
Amount Paid	

7-31-09