



# North Carolina Providers Council

**Bob Hedrick, MAEd, Executive Director**  
3722 Benson Drive, Suite 102. • Raleigh, NC 27609  
Phone: 919-850-4592 • Fax: 919-850-4593  
www.ncproviderscouncil.org

Please check as appropriate:

**New** \_\_\_\_\_

**Renewal** \_\_\_\_\_

## 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 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:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**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  
3722 Benson Drive, Suite 102  
Raleigh, NC 27609**

If you have any questions concerning membership, please contact the Raleigh office at (919) 850-4592 or email [diana.mills@ncproviderscouncil.org](mailto:diana.mills@ncproviderscouncil.org) or [claire.szaz@ncproviderscouncil.org](mailto:claire.szaz@ncproviderscouncil.org).

<b>For Internal Use Only</b>	
Date Received	
Date to Board	
Date to Membership	
Date Approved	
Check #	
Amount Paid	

6-11-08