North Carolina Providers Council
9660 Falls of Neuse Rd, Suite 138 #124, Raleigh, NC 27615
Phone: 919-784-0230 • Fax: 919-784-0231
www.ncproviderscouncil.org

APPLICATION FOR MEMBERSHIP (Providers of Services)

REFERRED BY: ____

DATE APPLICATION COMPLETED: ____

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

*Applicants can choose to join as: 1) Individual Agency/Corporation – Membership is for a single corporation based on revenues for a corporation and includes benefits and voting privileges for that corporation; or 2) Multiple Corporations under One Management Entity – One membership for multi-corporations under one management company based on total revenues for all agencies/corporations/owned/managed by the parent company in NC.

PART I: OWNER/CEO/PRESIDENT/EXECUTIVE DIRECTOR Signature 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/management entity and that any false information will be grounds for rejection of my application for NC Providers Council membership.

Signature:____

Printed Name:_________________________________ **Title:**_________________________________

Preferred Phone Contact: ☐**Office** ☐ **Cell** Cell Phone: ____________________________

Office Phone: ___________________________ Ext. _____ Fax: ______________________________

Mailing Address: ____

City/State/Zip: ____

Email:____________________________________ Website: ___________________________________

PART II: DESIGNATED VOTING MEMBER OF AGENCY:

Each agency can designate one person as the voting member for their agency.
If you would like to designate a person **other** than Owner/CEO/President for the voting member, please complete the contact information below.

Voting Member Signature:____

Printed Name:_________________________________ **Title:**_________________________________

Preferred Phone Contact: ☐**Office** ☐ **Cell** Cell Phone: ____________________________

Office Phone: ___________________________ Ext. _____ Fax: ______________________________

Mailing Address: ____

City/State/Zip: ____

Email:____________________________________ Website: ___________________________________

PART III: MEMBERSHIP DUES DETERMINATION AND VERIFICATION

A. Definition of Annual Revenue: The level of membership is determined by gross annual revenue, regardless of payer source for provision of services to children and adults related to the NC Department of Health and Human Services (Division of Mental Health, Developmental Disabilities, Substance Abuse; Division of Medical Assistance/ Medicaid; Division of Social Services, Division of Vocational Rehabilitation); Managed Care Organizations (MCOs)/ Local Management Entities (LMEs); Community Care/ North Carolina/ Carolina Access; or other state funds, county funds, private pay, or insurance funding for services and supports in North Carolina to people with mental health, intellectual/developmental disability, substance use abuse, or foster care.
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B. Verification of Annual Revenue for all membership levels:

- Submit verification from an independent Certified Public Accountant (CPA), financial consultant, or Agency CFO verifying and attesting to your gross revenue in NC.

C. Payment Options: **(Application must be filled out completely. Incomplete applications cannot be processed.)**

- (ANNUAL PAYMENT) you must enclose the full renewal amount payable to the NC Providers Council by the renewal date.
- (QUARTERLY PAYMENTS) If you would like to request quarterly payments, your request must be received before your expiration date in order to determine a pay schedule before your membership expires. Once approved, your 1st quarterly payment must be received within 30 days to keep your membership current.

D. Dues Levels

Check the appropriate box below based on your annual revenue (See III,A above):

Check Here:	Annual Revenue:	Annual Amount Due:	Quarterly Amount Due:	Number of member listserv addresses available per membership level
	$0 - $2,500,000	$3,000 per year	$750 per Q	6
	$2,500,001 - $5,000,000	$5,000 per year	$1,250 per Q	8
	$5,000,001 - $10,000,000	$7,000 per year	$1,750 per Q	10
	$10,000,001 - $25,000,000	$10,000 per year	$2,500 per Q	12
	$25,000,001 - $50,000,000	$13,000 per year	$3,250 per Q	14
	$50,000,001 - $75,000,000	$16,000 per year	$4,000 per Q	18
	$75,000,001 - $100,000,000	$19,000 per year	$4,750 per Q	20
	$100,000,001 - $125,000,000	$22,000 per year	$5,500 per Q	22
	$125,000,001 - $150,000,000	$25,000 per year	$6,250 per Q	25
	$150,000,001 – $175,000,000	$28,000 per year	$7000 per Q	28
	$175,000,001 - $200,000,000	$31,000 per year	$7750 per Q	31
	$200,000,001 - $225,000,000	$34,000 per year	$8500 per Q	34
	$225,000,001 - $250,000,000	$37,000 per year	$9250 per Q	37

The NC Providers Council is a nonprofit 501(C)(6) trade association. Dues and other contributions paid to this association are not deductible as charitable contributions for federal income tax purposes. However, payments of membership dues are deductible for some members of a trade association under Section 1662 of the Internal Revenue Code as an “ordinary and necessary business expense” and as determined by each member’s tax advisor. The estimated percent of the annual budget designated for “lobbying” activities is determined to be 10% of each member’s dues for the 2018-2019 membership year.

E. Signature: By my signature below I attest that the annual revenue indicated in III, D above is accurate and consistent with the definition of annual revenue in III A above.

__________________________________ ____
Signature of CPA, CFO or Financial Consultant   Printed Name and Date

Title:____

Name of Firm:____

QUESTIONS? Please email Carson Stanley at carson.stanley@ncproviderscouncil.org or call (919)784-0230.

PART IV: SERVICES PROVIDED

Voting Member, COO or Designee to complete the following:

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

A. In which MCOs/Imminent MCOs' counties do you provide services to consumers, or have employees at sites within those MCOs/Imminent MCOs?

☐ **Alliance Behavioral Healthcare**	☐ Cumberland ☐ Durham ☐ Johnston ☐ Wake
☐ **Cardinal Innovations Healthcare Solutions**	☐ Alamance ☐ Caswell ☐ Cabarrus ☐ Chatham ☐ Davidson ☐ Davie ☐ Forsyth ☐ Franklin ☐ Granville ☐ Halifax ☐ Mecklenburg ☐ Orange ☐ Person ☐ Rockingham ☐ Rowan ☐ Stanly☐ Stokes ☐ Union ☐ Vance ☐ Warren
☐ **Trillium Health Resources**	☐ Beaufort ☐ Bertie ☐ Brunswick ☐ Camden ☐ Carteret ☐ Chowan ☐ Craven ☐ Currituck ☐ Dare ☐ Gates ☐ Hertford ☐ Hyde ☐ Jones ☐ Martin ☐ New Hanover ☐ Northampton ☐ Onslow ☐ Pamlico ☐ Pasquotank ☐ Pender ☐ Perquimans ☐ Pitt ☐ Tyrrell ☐ Washington
☐ **Eastpointe**	☐ Bladen ☐ Columbus ☐ Duplin ☐ Edgecombe ☐ Greene ☐ Lenoir ☐ Nash ☐ Robeson ☐ Sampson ☐ Scotland ☐ Wayne ☐ Wilson
☐ **Partners Behavioral Health Management**	☐ Burke ☐ Catawba ☐ Cleveland ☐ Gaston ☐ Iredell ☐ Lincoln ☐ Surry ☐ Yadkin
☐ **Sandhills Center**	☐ Anson ☐ Guilford ☐ Harnett ☐ Hoke ☐ Lee ☐ Montgomery ☐ Moore ☐ Randolph ☐ Richmond
☐ **Vaya Health**	☐ Alexander ☐ Alleghany ☐ Ashe ☐ Avery ☐ Buncombe ☐ Caldwell ☐ Cherokee ☐ Clay ☐ Graham ☐ Haywood ☐ Henderson ☐ Jackson ☐ Macon ☐ Madison ☐ McDowell ☐ Mitchell ☐ Polk ☐ Rutherford ☐ Swain ☐ Transylvania ☐ Watauga ☐ Wilkes ☐ Yancey

To whom does your agency provide services? Please indicate numbers below. If none, please put "0":

B. What is the total # of people with Intellectual/Developmental Disabilities (I/DD): Children_____Adults_____
What is the total # of people with mental illness (MI): Children_____Adults_____
What is the total # of people w/ substance abuse/other addictive diseases (SA): Children_____Adults_____

C. Please provide the total number of paid staff positions (full-time, part-time, contract) for your agency--need the number of jobs represented/people affected (data will remain confidential): ___________________

D. Is your agency nationally accredited? 1. ☐No If yes, check below which applies,

1. ☐Yes The Commission on Accreditation and Rehabilitation Facilities (CARF)
2. ☐Yes The Council on Accreditation (COA)
3. ☐Yes The Council on Quality and Leadership (CQL)
4. ☐Yes The Joint Commission (JCAHO)

E. Is your agency certified as a Critical Access Behavioral Health Agency (CABHA)? 1. ☐Yes 2. ☐No

F. Please indicate the services that you provide to persons with intellectual/developmental disabilities (I/DD).

☐ Residential-ICF/IDD
☐ Residential DDA, AFL or Supervised Living program
☐ Innovations Waiver Services/ (CAP MR-DD) Community Alternatives Program for People with I/DD
☐ State funded services for I/DD – (IPRS Funded)
☐ I/DD Targeted Case Management
☐ Crisis Services, including NC START
☐ Adult Day Vocational Programs (ADVPs)

G. Please indicate the services your agency provides to persons with mental illness (MH) or substance abuse/addictive diseases (SA).

- ☐ CABHA core services to children (intensive in-home, day treatment)
- ☐ CABHA core services to adults (community support team)
- ☐ MH/SA, Targeted Case Management
- ☐ Outpatient Therapy
- ☐ Vocational Rehabilitation
- ☐ Psycho-Social Rehab (PSR)
- ☐ Residential-Foster Care, Licensed Child Placement Agency
- ☐ Children's Residential Level II-IV
- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Residential services to adults
- ☐ State funded services for MH (IPRS Funded)
- ☐ Facility Based Crisis
- ☐ Walk-In Crisis
- ☐ Residential options/24 hour care
- ☐ State funded services SA (IPRS)
- ☐ Intensive In-Home (IIH)
- ☐ ACTT
- ☐ Peer Support
- ☐ SAIOP
- ☐ SACOT
- ☐ DETOX Services

Part III – List Below All Employees to Receive Membership Listserv Emails:

Depending upon dues level, each agency may identify individuals to receive emails via the NC Providers Council member listserv. (See dues structure chart on page 2)

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:______________________________________

23) Name:_____________________________________ Email:____

Title:______________________________________

24) Name:_____________________________________ Email:____

Title:______________________________________

25) Name:_____________________________________ Email:____

Title:______________________________________