North Carolina Providers Council
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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 may 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. 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 may designate one person as a voting member for the 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. Payer sources may include the NC Department of Health and Human Services (Division of Mental Health, Developmental Disabilities, Substance Abuse; Division of Health Benefits / Medicaid; Division of Social Services, Division of Vocational Rehabilitation); Local Management Entity - Managed Care Organizations (LME/MCOs); Community Care of North Carolina/ Carolina ACCESS; or other State funds, county funds, private pay, or insurance funding for services and supports in North Carolina to individuals who need mental health, intellectual/developmental disability, substance abuse, or foster care services.

B. Verification of Annual Revenue for all membership levels:

- Submit verification from an independent Certified Public Accountant (CPA), financial consultant, or Agency CFO attesting to your corporation's 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 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 corporation's annual revenue in NC (See III A above):

Check Here:	Annual Revenue:	Annual Amount Due:	Quarterly Amount Due:
	$0 - $2,500,000	$3,000 per year	$750 per Q
	$2,500,001 - $5,000,000	$5,000 per year	$1,250 per Q
	$5,000,001 - $10,000,000	$7,000 per year	$1,750 per Q
	$10,000,001 - $25,000,000	$10,000 per year	$2,500 per Q
	$25,000,001 - $50,000,000	$13,000 per year	$3,250 per Q
	$50,000,001 - $75,000,000	$16,000 per year	$4,000 per Q
	$75,000,001 - $100,000,000	$19,000 per year	$4,750 per Q
	$100,000,001 - $125,000,000	$22,000 per year	$5,500 per Q
	$125,000,001 - $150,000,000	$25,000 per year	$6,250 per Q
	$150,000,001 – $175,000,000	$28,000 per year	$7000 per Q
	$175,000,001 - $200,000,000	$31,000 per year	$7750 per Q
	$200,000,001 - $225,000,000	$34,000 per year	$8500 per Q
	$225,000,001 - $250,000,000	$37,000 per year	$9250 per Q

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 2019-2020 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:_____

PART IV: SERVICES PROVIDED

Voting Member, COO or Designee: please complete the following to assist the NC Providers Council with representing providers collectively at the NC General Assembly and DHHS.

A. In which LME/MCOs catchment areas do you provide services to consumers, or have employees at sites?

☐ **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 ☐ Columbus ☐ Craven ☐ Currituck ☐ Dare ☐ Gates ☐ Hertford ☐ Hyde ☐ Jones ☐ Martin ☐ Nash ☐ New Hanover ☐ Northampton ☐ Onslow ☐ Pamlico ☐ Pasquotank ☐ Pender ☐ Perquimans ☐ Pitt ☐ Tyrrell ☐ Washington
☐ **Eastpointe**	☐ Bladen ☐ Duplin ☐ Edgecombe ☐ Greene ☐ Lenoir ☐ 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 in NC? Please indicate numbers below. If none, please put "0":

B. Total # of people with Intellectual/Developmental Disabilities (I/DD): Children_____Adults_____
Total # of people with mental illness (MI): Children_____Adults_____
Total # of people w/ substance abuse/other addictive diseases (SA): Children_____Adults_____
Total # of children in Foster Care: _____

C. Please provide the total number of paid staff positions (full-time, part-time, or contract) for your corporation in NC (data will remain confidential): _____

D. Is your agency nationally accredited? ☐No

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/C
- ☐ CAP/DA
- ☐ 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 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)
- ☐ 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 or MAT Services

Part V –Employees to Receive Membership Listserv Emails:

Each agency may identify individuals to receive emails via the NC Providers Council member listserv. Members receive listserv communications including the bi-weekly CMS/DHHS/LME-MCO Update newsletter to assist them in staying abreast of federal and State policy issues and legislative activity.

1) Name:_____ Email:_____

2) Name:_____ Email:_____

3) Name:_____ Email:_____

4) Name:_____ Email:_____

5) Name:_____ Email:_____

6) Name:_____ Email:_____

7) Name:_____ Email:_____

8) Name:_____ Email:_____

9) Name:_____ Email:_____

10) Name:_____ Email:_____

11) Name:_____ Email:_____

12) Name:_____ Email:_____

13) Name:_____ Email:_____

14) Name:_____ Email:_____

15) Name:_____ Email:_____

16) Name:_____ Email:_____

17) Name:_____ Email:_____

18) Name:_____ Email:_____

19) Name:_____ Email:_____

20) Name:_____ Email:_____

21) Name:_____ Email:_____

22) Name:_____ Email:_____

23) Name:_____ Email:_____

24) Name:_____ Email:_____

25) Name:_____ Email:_____