



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

*Provider Support Application

Name of person completing application:

Date:

Part I

Company Name:
Brief Description of Company:
Mailing Address:
City/State/ZIP:
Telephone and Ext:
Fax:
Website (for link):
Number of Years in Business:
Location of Corporate Office:
Locations (Geographic Region(s) Served in NC Only):
List other states served:

Part II

***Definition of a Provider Support Member:** *A Provider Support Member is a company, agency or individual who provides services or products to agencies/companies who serve adults and children requiring MH/DD/SA services. Services/products may include management, consulting, billing and other ancillary services. Provider Support Members sell software, van fleet management, insurance, billing systems, consulting services, medical equipment and supplies, training systems, furniture, etc. to providers of services to people requiring MH/DD/SA services. Provider Support Members do not typically provide services directly to consumers of MH/DD/SA services.*

Annual Dues: \$2,000

Membership Year: The membership year begins the first day of the month following Board approval. All Provider Support Members are welcome to attend membership meetings.

Benefits: Provider Support Members in good standing will receive the following member benefits:

- Brief presentation defining product or service at a monthly membership meeting
- Link from NC Providers Council website to Provider Support Member website
- Communication emails via NC Providers Council members only listserv to designated employee(s)**
- Exhibit booth discount at NC Providers Council Annual Conference
- Acrylic membership plaque with mahogany stand

***Provider Support Members can request to receive communications, including the bi-weekly CMS/DHHS/LME-MCO Update newsletter, via the Providers Council membership listserv to assist them in staying abreast of important provider issues and better serve the needs of the NC Providers Council membership. E-mail messages, including any attachments, are for the sole use and benefit of NC Providers Council members.. Unauthorized review, use, disclosure, or distribution to anyone other than employees of your agency/corporation is prohibited. Provider Support Members shall not initiate electronic/e-mail marketing to member agencies/companies, but may market to Providers Council membership through direct mail, direct contact with members as defined in the Benefits section above, and in response to a member's inquiry about the Provider Support Member's services or products.*

Part III

Listserv Contact Information

The following individual will receive email communications via the NC Providers Council listserv. If you do not wish to receive communications, please check below.

Contact Name: _____

Title: _____ **Email:** _____

I do not wish to receive communications via the NC Providers Council listserv.

Part IV

Sharing of Company Information

I agree to allow the NC Providers Council to share my company contact information with fellow members as part of normal membership communications including conference materials.

Part V

Signature of Authorized Representative

I have read and I understand the NC Providers Council's Code of Ethics and agree to conduct business consistent with the spirit and intent of this Code of Ethics and to abide by the ethical standards of my

trade/industry. I further agree that no employee of our company (or its affiliates, as applicable) will market to the NC Providers Council membership via email unless a provider member initiates the communication. I certify that the information I have provided accurately represents my business. I further understand that providing any false information on this application or violating the ethical standards as defined above will be grounds for rejection of my application or termination of the NC Providers Council's Provider Support Membership and may include forfeiture of any annual dues credit remaining as of the effective date of membership termination.

PART VI: 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. 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. Termination may include forfeiture of any annual dues credit remaining as of the effective date of membership termination.

Signature: _____

Printed Name: _____ **Title:** _____

Primary Phone Choice: Office Cell Cell Phone: _____

Office Phone: _____ Ext. _____ Fax: _____

Mailing Address: _____

City/State/Zip: _____

Email: _____ Website: _____

Application must be filled out completely. Incomplete applications cannot be processed. Please enclose your check for \$2,000 payable to: NC Providers Council and return to:

**NC Providers Council
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If you have questions concerning your Provider Support Membership, please contact Carson Stanley at carson.stanley@ncproviderscouncil.org