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www.mhacentralcarolinas.org

MHA Directory of Mental Health Professionals Membership Benefits & Application/Attestation Form

- General Membership Benefits: *Why join or renew your membership with MHA?*
 - Increase the visibility of your practice on the MHA website and other modes of communication, depending on your level of participation – all membership levels (except Supporter Level) include a one-year listing on the MHA website which averages over 4,000 hits per month. The ***“Find a Practitioner” page is the most frequently visited page on the MHA website, (www.mhacentralcarolinas.org) after the home page.***
 - Belong to an inclusive and well respected network of advocates and mental health professionals.
 - Network with other mental health professionals in the region.
 - Hear about educational opportunities to earn Continuing Education Credits (CEUs).
 - Access to high quality mental health information resources.
 - Receive the latest information in the field of mental health through “e-News”, Newsletters, Advocacy Alerts, etc.), as well as reports from Mental Health America, our national affiliate.
 - Provide a tax-deductible contribution to the only nonprofit in the region focused on mental health advocacy, education and prevention (cost of membership will be discounted; final tax-deductible contribution dependent on membership level).
 - **Support the only local, nonprofit mental health advocacy agency with a 78-year history of promoting mental wellness through advocacy, education and prevention initiatives in Mecklenburg & Cabarrus Counties.**

- ***Supporter Level (\$50-99) – Students of Mental Health or Professionals interested in networking and info sharing without the need to promote a practice (note the higher level of giving, the more of a tax-deductible contribution)***
 - *All benefits described above in General Membership Benefits, excluding listing on the MHA website but including:*
 - One-time listing in the *MHA Annual Report*
 - Opportunities to volunteer with the MHA (e.g., Board of Directors, provide educational talks to target consumer audiences, submit articles for eNews and print newsletters, and serve as media liaison, as needed, etc.)
 - Network with other provider professionals through the *MHA Annual Mental Health Professional Networking Event* (one ticket)

- **Subscriber Level (\$100-\$149) – Individual Mental Health Professionals** (note the higher level of giving, the more of a tax-deductible contribution)
 - All benefits described above in General Membership Benefits, including:
 - One-time listing in the MHA Annual Report
 - Opportunities to volunteer with the MHA (e.g., Board of Directors, provide educational talks to target consumer audiences, submit articles for eNews and print newsletters, and serve as media liaison, as needed, etc.)
 - Network with other provider professionals through the MHA Annual Mental Health Professional Networking Event (one ticket)

- **Networker Level (\$150 base level and up) – Individual Mental Health Professionals**
 - All the benefits described in Subscriber level, including **two** tickets for the MHA Annual Mental Health Professional Networking Event and benefits listed here
 - **One annual listing (includes one picture, which is optional) in the online and printed publication of “The Networker – Psychotherapy Groups”** (directory of psychotherapy groups, print publication formerly maintained by Dr. Nona Patterson; subsequent listings and pictures may be included for an additional cost of \$50 per listing and/or picture)

- **Group Level (\$250 base level and up) - Group Providers, Hospitals, and/or LMEs**
 - All the benefits described in Subscriber level, including **three** tickets for the Annual Mental Health Professional Networking Event and benefits listed here
 - **“Featured Mental Health Professional” recognition which will include an embedded hotlink to provider website, located on MHA website home page**
 - Special recognition at the MHA Annual Mental Health Professional Networking Event on printed and electronic communications, event signage, etc.
 - Note: Individual mental health professionals within the Group Provider may opt to have a separate individual membership at the *Subscriber* or *Networker* levels for a 50% discount
 - For satellite offices, please add an additional \$50 per office site

Membership Criteria: (Members must maintain the minimum of the following to be added/maintained on the website or in “The Networker – Psychotherapy Groups” publication.)

- Professional and current licensure/certification (does not apply to Supporter level)
- Professional Liability Insurance with a minimum coverage of \$1,000,000/\$3,000,000 or \$2,000,000/\$2,000,000 (does not apply to Supporter level)
- Completed membership application & attestation form
- Membership paid in full

To correspond with the MHA’s fiscal year, the membership runs from July 1-June 30. Membership rates are pro-rated each quarter as follows:

| Join-End Dates | Supporter | Subscriber | Networker | Group |
|----------------|-----------|------------|-----------|-------|
| July-June | \$50 | \$100 | \$150 | \$250 |
| Oct.-June | \$37 | \$75 | \$113 | \$188 |
| Jan.-June | \$25 | \$50 | \$75 | \$125 |
| Apr.-June | \$13 | \$25 | \$38 | \$63 |



MHA Directory of Mental Health Professionals – Application & Attestation Form

Please select one of the following:

- Renewal – Individual/Group** (if renewing and directory info has not changed, you only need to complete this page and provide updated copy of licensure, insurance liability and attestation form with payment.)
- New Member – Individual/Group**
- Individual Mental Health Prof of Group** (50% discount on Subscriber or Networker)
_____ (list Group Member here)

I am interested in joining the MHA Directory of Mental Health Professionals at the following level:

- Supporter Level** (\$50)
- Subscriber Level** (\$100)
- Networker Level** (\$150) Please add \$50 per listing (if more than one listing or picture in “The Networker – Psychotherapy Groups”; see below and check appropriate line/s; add additionally requested benefits to total)
- Group Level** (\$250) Please add \$50 per satellite office; see below

Additional Benefits (only available at Networker and Group Levels):

- 2nd Picture in “The Networker – Psychotherapy Groups” – add \$50 to membership
- 3rd Picture in “The Networker – Psychotherapy Groups” – add \$100 to membership
- 4th Picture in “The Networker – Psychotherapy Groups” – add \$150 to membership
- 2nd Listing in “The Networker – Psychotherapy Groups” – add \$50 to membership
- 3rd Listing in “The Networker – Psychotherapy Groups” – add \$100 to membership
- 4th Listing in “The Networker – Psychotherapy Groups” – add \$150 to membership
- 1st Satellite Office – add \$50 to membership
- 2nd Satellite Office – add \$100 to membership
- 3rd Satellite Office – add \$150 to membership

I understand that this selected level of membership is effective for one year (July 1-June 30 of the following year) if received by MHA no later than June 30th, and includes the benefits specified in “Membership Benefits”, which accompanied this form. If unable to join before June 30, see bottom of page 2 for pro-rated membership rates.

Signature/Credentials

Date

Total Payment = _____ (includes membership fees plus extra costs, such as The Networker listings/pictures; satellite offices; etc; where applicable). Payments may be made on our secure site (www.mhacentralcarolinas.org Click here to Donate Online! and indicate MEMBERSHIP in comments) or mailed with this application to 3701 Latrobe Drive, Ste 140, Charlotte, NC 28211, Attn: Membership

Please indicate preference for payment (cash is not accepted):

- I have submitted payment online.
- My check is enclosed.
- Credit Card: VISA M/C AMEX DSCVR Card Number: _____
Expiration Date: _____ security code: _____ (3 or 4 digit code on back of card)

Please complete the following information for membership: (Please submit before June 30th.)
For Group Members, please attach a separate sheet with listings of satellite locations (each location subject to additional charge, see previous pages).

Name of Member (Individual and/or Group): _____

Contact Person (if Group): _____

Credentials _____ Salutation: Mr. Mrs. Ms. Dr. (Please circle your preference)

Address – Office (Main) _____

Address – Mailing (if different than office): _____

Local Telephone and/or Toll Free Number: _____

Website: _____

Email: _____

Professional

License/Certification Number _____

--Attach a copy of current license/certification (not required at Supporter level)

Professional Liability Insurance with minimum coverage of \$1,000,000/\$3,000,000 or \$2,000,000/\$2,000,000

--Attach a copy of the policy cover sheet (not required at Supporter level)

EDUCATION

Highest Degree

Earned _____ Date _____

Institution _____

Discipline _____

Other Graduate

Degree _____ Date _____

Institution _____

Discipline _____

Undergraduate

Degree _____ Date _____

Institution _____

Discipline _____

PROFESSIONAL

Hospital Privileges (List) _____

YOUR PRACTICE

Consumer/Client Populations (Please check appropriate areas.)

- Child Adolescent Adult Geriatric Family
- I am a School Psychologist practicing only within the school system
- I am a Student I am not currently practicing but wish to maintain a professional network and support the MHA (if you are not in private practice, you may skip the rest of page 5 and page 6 until you reach Opportunities to Volunteer)

Evidence of Cultural Competence (Please provide evidence of cultural and/or linguistic practice within the organization and toward the consumers; check all that apply.)

Evidence of Cultural & Linguistic Populations Served:

- Persons with Hearing Impairment Persons with Speech Impairment Persons with Visual Impairment
- Latinos Montagnards Hmong Burmese Napelese
- Africans Iraqis Vietnamese Cambodians Laotians Native Americans
- African-Americans
- Other: _____

Evidence of cultural/linguistic competence within the organization (please specify number of employees and their cultural backgrounds and languages spoken):

Problems/Disorders Treated (Choose only six.)

- | | | |
|---|--|---|
| 1. <input type="checkbox"/> Adjustment Disorders | 12. <input type="checkbox"/> Gay/Lesbian Issues | 21. <input type="checkbox"/> Schizophrenia/Psychoses |
| 2. <input type="checkbox"/> Anxiety Disorders | 13. <input type="checkbox"/> HIV/AIDS | 22. <input type="checkbox"/> School Issues |
| 3. <input type="checkbox"/> Attention Deficit Disorders | 14. <input type="checkbox"/> Impulse Disorders | 23. <input type="checkbox"/> Sexual/Physical Abuse |
| 4. <input type="checkbox"/> Bipolar Disorders | 15. <input type="checkbox"/> Marital Relations/Divorce | 24. <input type="checkbox"/> Sexuality/Sexual Dysfunction |
| 5. <input type="checkbox"/> Co-Dependency | 16. <input type="checkbox"/> Mental Retardation/Developmental Disabilities | 25. <input type="checkbox"/> Somatoform Disorder/Chronic Pain |
| 6. <input type="checkbox"/> Crisis Intervention | 17. <input type="checkbox"/> Neuropsychology | 26. <input type="checkbox"/> Substance Abuse |
| 7. <input type="checkbox"/> Depressive Disorders | 18. <input type="checkbox"/> Obsessive-Compulsive Disorder | 27. <input type="checkbox"/> Other (Specify): |
| 8. <input type="checkbox"/> Dissociative Disorders | 19. <input type="checkbox"/> Personality Disorder | _____ |
| 9. <input type="checkbox"/> Eating Disorders | 20. <input type="checkbox"/> Posttraumatic Stress Disorder | _____ |
| 10. <input type="checkbox"/> Family Therapy/Parenting | | _____ |
| 11. <input type="checkbox"/> Forensic Evaluations | | |

Fee Structure

- My services can be covered by insurance. Yes No
- I accept direct assignment of insurance benefits. Yes No
- I offer sliding scale fees for services. Yes No
- I participate in managed health care networks. Yes* No

*If yes, please check appropriate boxes on the next page or you may write in *Contact Provider for Details* to be put in your listing of managed health care networks. (Note: In the *other* category, there must be at least five other applying professionals in a managed health care program in order for that particular company to be listed.)

1. Aetna U.S. Healthcare
2. Blue Cross/Blue Shield
3. Champus/TRICARE
4. CIGNA
5. CMG Health
6. Family Enterprises
7. First Health
8. Fortis Insurance Company
9. Great-West
10. Green Spring Health
11. Guardian Life Insurance Company
12. Humana
13. Integra
14. John Alden Life Insurance Company
15. Magellan Behavioral Health
16. Managed Health Network
17. Medicaid
18. Medicare
19. Occupational Health
20. OHS/Foundation
21. Options Mental Health
22. Pacific Life
23. Principal Life Insurance Company
24. Provident Preferred
25. Prucare
26. Unicare
27. United Behavioral Health
28. United HealthCare
29. ValueOptions
30. WellPath
31. Other _____

Listing for “The Networker -Psychotherapy Groups” publication (if applicable; additional fee required for more than one listing at Networker level of membership)

For additional listings, please attach a separate sheet with the following information.

For pictures, please send to: mha@mhacentralcarolinas.org (only digital pictures will be accepted)

Title of Psychotherapy Group: _____

Brief Description of Group: _____

Group Time, Location: _____

Target Audience for Group: _____

Cost: _____

Group Leader(s): _____

For multiple group leaders, please attach a separate copy of each mental health professionals’ licensure, liability insurance, and attestation form on the next page (exclusions apply only if professionals are MHA Members).

Email/Website for more information: _____

Finally, the MHA invites you to participate in our mission through various volunteer roles within our organization.

Please check any below that may interest you.

Opportunities to Volunteer:

- ___ Serve on the MHA Board of Directors
- ___ Collaborate on Suicide Prevention Trainings with MHA Certified QPR (Question, Persuade, Refer) Trainers
- ___ Attend educational talks/presentations on a specific disorder
- ___ Lead presentation on a specific topic. List topics: _____
- ___ Submit articles and news for MHA eNews and printed newsletters
- ___ Serve as media liaison, as needed (addressing the media as part of a community response to timely issues)
- ___ Serve on planning committee for networking events
- ___ Join Coalition on Immigrant/Refugee Mental Health; interest in attending Torture & Trauma Training



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MHA Directory of Mental Health Professionals – Attestation Form

(Each mental health professional listed on the *MHA Online Directory of Mental Health Professionals* and in *The Networker – Psychotherapy Groups*, both online and published versions, must complete this form, and send in with a copy of licensure and proof of liability insurance.)

Applicants agree that they shall advise the Mental Health Association of Central Carolinas, Inc. at 3701 Latrobe Drive, Suite 140; Charlotte, NC 28211 by registered mail within thirty days of the occurrence of any of the following events: (This form must be completed and returned by June 30, the beginning of membership period.)

1. any events in which he/she has been found guilty of unethical or unprofessional conduct by the Ethics Committee of their respective discipline, the state licensing board, or the licensing or certification board or professional association in any jurisdiction;
2. any events in which he/she had professional liability insurance cancelled for ethics violations;
3. any events in which he/she has been found guilty of unethical or unprofessional conduct by any professional organization or any board of registry or certification;
4. any events in which he/she has been found guilty of unethical or unprofessional conduct or incompetency in the provision of services, or in which his/her scope of practice has been limited by any health service provider organization;
5. any legal claims or judgments against him/her (pending or concluded) related to his/her professional practice; or,
6. current investigations being undertaken relative to any of the above events.

This reporting obligation exists regardless of any appeal or other proceedings related to the original event.

Has there been any event which triggers any of the reporting requirements described above? If so, please attach an explanation and describe the current status and findings of any investigation or proceedings.

_____ I have nothing to report.

_____ All reportable matters are described on the attached sheet, and upon request, I agree to provide releases for the Mental Health Association of Central Carolinas, Inc. to secure materials from any parties having knowledge of these matters.

I hereby attest that the preceding statement and any attached information are true, complete, and accurate to the best of my knowledge and belief.

Further, I agree to indemnify and hold harmless the Mental Health Association of Central Carolinas, Inc., and each of its officers, members, directors, or employees in connection with the use of any information contained in the online Directory of Mental Health Professionals.

Date: _____

Signature: _____