



3701 Latrobe Drive, Suite 140
Charlotte, NC 28211
704.365.3454 Phone
www.mhacentralcarolinas.org

MHA Membership for Mental Health Professionals

Membership Benefits & Application/Attestation Form

MHA offers professional membership for our fiscal year of July 1, 2019-June 30, 2020. As a mental health professional, your membership with the MHA links you to the area's oldest and largest nonprofit organization in North Carolina solely dedicated to promoting mental wellness through advocacy, education, and prevention.

Membership Benefits: *Why join or renew your membership with MHA?*

- Increase the visibility of your practice on the MHA website. The MHA website averages 1,500-2,000 unique visitors per month. The directory is most visited page 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.
- Be informed of educational opportunities to earn Continuing Education Credits (CEUs).
- Receive the latest information in the field of mental health through newsletters, advocacy alerts, and reports from Mental Health America, our national affiliate.
- **Support the only local, nonprofit mental health agency with an 86 year history of promoting mental wellness through advocacy, education and prevention initiatives in Mecklenburg & Cabarrus Counties. (Your fee is partially tax-deductible and depends on Level joined.)**

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
- 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

Membership Levels and Benefits

	Individual Level \$100	Group Level \$250
2019-2020 Membership Benefits		
One-time listing in the MHA Annual Report.	X	X
Opportunities to volunteer with the MHA (Board of Directors; educational talks to target audiences; submission of articles for newsletters; serve as media liaison.)	X	X
Network with other providers through the MHA Mental Health Professional Networking Event.	1 ticket	3 tickets
Listing in the MHA online directory of mental health professionals at www.mhacentralcarolinas.org .	X	X
Option to be featured at one of MHA's monthly Coffee & Conversation events featuring local Storytellers sharing stories of hope and recovery (will be offered an opportunity to highlight group practice.) Learn more about Coffee & Conversation on the MHA website.		X
"Featured Mental Health Professional" recognition on MHA website home page which will include an embedded link to provider website.		X

Membership Fees

	Price	Amount
Subscriber Level for Individual Listings	\$100	
Group Level for Group Practices	\$250	
For Groups only: additional satellite office listings	\$50 each	
Discount for joining prior to 5/31/2019	(\$20)	
Total Amount Due – enter here _____	_____	_____

Please select payment method:

_____ I have submitted payment online (www.mhacentralcarolinas.org, *Donate Now* and indicate MEMBERSHIP in comments)

_____ My check is enclosed. Mail to 3701 Latrobe Drive, Suite 140, Charlotte, NC 28211

_____ Credit Card: VISA M/C AMEX DSCVR Card Number: _____

Exp. Date: _____ security code: _____ (3 or 4 digit code on back of card)

*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 Levels and Benefits", which accompanied this form. **If unable to join before June 30, contact the MHA for pro-rated membership fees.***

Signature/Credentials

Date

Please complete the following for website listing:

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

Contact Person (if Group): _____

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

Preferred Title (i.e., Psychotherapist, Psychiatrist) _____

Address – Office (Main) _____

Address – Mailing (if different than office): _____

Local Telephone and/or Toll Free Number: _____

Website: _____

Include email address on website, Yes: ___ No: ___ 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 LGBTQ Athletes Parents Toddlers/Preschoolers
 Young Adults First Responders Immigrants & Refugees

- I am a School Psychologist/Counselor/Social Worker practicing within 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 until you reach Opportunities to Volunteer on page 7)

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 Bhutanese 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 TOP SIX treatment areas.)

- | | | |
|---|--|---|
| 1. <input type="checkbox"/> Acute care for immediate hospitalizations | 14. <input type="checkbox"/> Eating Disorders | 29. <input type="checkbox"/> Posttraumatic Stress Disorder |
| 2. <input type="checkbox"/> Adjustment Disorders | 15. <input type="checkbox"/> Emotional Trauma | 30. <input type="checkbox"/> Psychological Assessments |
| 3. <input type="checkbox"/> Anxiety Disorders | 16. <input type="checkbox"/> Family Therapy/ Parenting | 31. <input type="checkbox"/> Schizophrenia/ Psychoses |
| 4. <input type="checkbox"/> Attention Deficit Disorders | 17. <input type="checkbox"/> Forensic Evaluations | 32. <input type="checkbox"/> School Issues |
| 5. <input type="checkbox"/> Autism/Asperger's | 18. <input type="checkbox"/> Gay/Lesbian Issues | 33. <input type="checkbox"/> Self-Injury |
| 6. <input type="checkbox"/> Bipolar Disorders | 19. <input type="checkbox"/> Grief/Bereavement | 34. <input type="checkbox"/> Sexual/Physical Abuse |
| 7. <input type="checkbox"/> Brain Injury/ Concussions | 20. <input type="checkbox"/> HIV/AIDS | 35. <input type="checkbox"/> Sexuality/Sexual Dysfunction |
| 8. <input type="checkbox"/> Co-Dependency | 21. <input type="checkbox"/> Impulse Disorders | 36. <input type="checkbox"/> Somatoform Disorder/Chronic Pain |
| 9. <input type="checkbox"/> Communication/ Relationship skills | 22. <input type="checkbox"/> Intellectual/ Developmental Disorders | 37. <input type="checkbox"/> Sports Mindfulness/ Training |
| 10. <input type="checkbox"/> Crisis Intervention | 23. <input type="checkbox"/> Life balance/ Personal Growth | 38. <input type="checkbox"/> Substance Abuse |
| 11. <input type="checkbox"/> Depressive Disorders | 24. <input type="checkbox"/> Marital Relations/Divorce | 39. <input type="checkbox"/> Other (Specify): _____ |
| 12. <input type="checkbox"/> Dissociative Disorders | 25. <input type="checkbox"/> Neuropsychology | |
| 13. <input type="checkbox"/> DWI Assessments/ Treatment | 26. <input type="checkbox"/> Obsessive- Compulsive Disorder | |
| | 27. <input type="checkbox"/> Obesity/Weight Mgt. | |
| | 28. <input type="checkbox"/> Personality Disorder | |

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.)*

Please check all insurance types you accept:

- | | |
|--|---|
| 1. <input type="checkbox"/> Aetna Life Insurance Company | 13. <input type="checkbox"/> John Alden Life Insurance Company |
| 2. <input type="checkbox"/> Aetna Health, Inc. | 14. <input type="checkbox"/> Magellan Behavioral Health |
| 3. <input type="checkbox"/> All Savers Insurance Co. | 15. <input type="checkbox"/> MedCost Preferred |
| 4. <input type="checkbox"/> Blue Cross Blue Shield of NC | 16. <input type="checkbox"/> Medicaid |
| 5. <input type="checkbox"/> Champus/TRICARE | 17. <input type="checkbox"/> Medicare |
| 6. <input type="checkbox"/> CIGNA Health | 18. <input type="checkbox"/> National Foundation Life Insurance Co. |
| 7. <input type="checkbox"/> Coventry Health and Life Insurance Co. | 19. <input type="checkbox"/> Private HealthCare Systems |
| 8. <input type="checkbox"/> Coventry Health Care of the Carolinas | 20. <input type="checkbox"/> Time Insurance Company |
| 9. <input type="checkbox"/> Federated Mutual Insurance Company | 21. <input type="checkbox"/> United Behavioral Health |
| 10. <input type="checkbox"/> First Access | 22. <input type="checkbox"/> United HealthCare |
| 11. <input type="checkbox"/> First Health | 23. <input type="checkbox"/> Other _____ |
| 12. <input type="checkbox"/> Humana | 24. <input type="checkbox"/> Contact provider for details |

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

Please check any below that may interest you. . .

Opportunities to Volunteer or Become More Engaged:

- ___ Volunteer on the MHA Board of Directors or a program committee
- ___ Volunteer for Compeer (a one-on-one friendship match with a same gender adult with chronic mental illness)
- ___ Serve as media liaison, as needed (addressing the media as part of a community response to timely issues)
- ___ Collaborate on Suicide Prevention Trainings with MHA Certified QPR (Question, Persuade, Refer) Trainers
- ___ Attend educational talks/presentations on a specific disorder Topics of interest: _____
- ___ Lead presentation on a specific topic. List topics: _____
- ___ Submit articles and news for MHA eNews and print newsletters. List topics: _____
- ___ Serve on planning committee for networking events
- ___ Would like to learn more about Pro-bono Counseling (future opportunity for the MHA)
- ___ Willing to create and manage MHA Linked In group for mental health professional members
- ___ Attend monthly Coffee & Conversation at MHA to meet others interested in promoting mental wellness and broaden your network



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*, 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 30 days of the occurrence of any of the following events: (Form must be completed and returned by July 1, 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 America of Central Carolinas 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: _____