Mental Health America of Central Carolinas
Advocacy | Education | Prevention

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

MHA Membership for Mental Health Professionals

Membership Benefits & Application/Attestation Form

MHA offers professional membership for our fiscal year of July 1, 2023-June 30, 2024. 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 is now averaging over 2,200 unique visitors per week thanks to a current marketing campaign, "My Mental Health Matters. And So Does Yours." Learn more at our Caring for Communities of Color page.
- Belong to an inclusive and well-respected network of advocates and mental health professionals.
- Network with other mental health professionals in the region.
- Participate in quarterly clinician round tables engaging policy, best practices, victories and struggles.
- 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 that has been promoting mental wellness since 1933 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

Completed applications may be scanned and emailed to mha@mhacentralcarolinas.org (payment of fees can be made online) or mailed to 3701 Latrobe Drive, Suite 140, Charlotte, NC 28211. Any questions? Call 704-365-3454 ext. 223. Fax # is 704-365-9973.

Membership Levels and Benefits

2023-2024 Membership Benefits	Individual Level $100	Group Level $250
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 Events. (virtual & in-person)	1 ticket	3 tickets
Listing in the MHA online directory of mental health professionals at www.mhaofcc.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" speaker on MHA's Mental Health Matters virtual talk show as expert		X
Participate in MHA Focus Group, as a Media Liaison, Volunteer Expert or more	X	X
Opportunity to sign a Memorandum of Understanding to be a part of MHA's Pro-bono Short-term Counseling project. MHA will pay an hourly rate for 6 sessions of Mecklenburg and Cabarrus youth and adults impacted by the pandemic, who could not otherwise afford counseling.	X	X

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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	
Total Amount Due – enter here →		

Please select payment method:

_____ I have submitted payment online (www.mhaofcc.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*

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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 _____

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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. ☐Acute care for immediate hospitalizations
2. ☐ Adjustment Disorders
3. ☐Anxiety Disorders
4. ☐Attention Deficit Disorders
5. ☐Autism/Asperger's
6. ☐Bipolar Disorders
7. ☐Brain Injury/ Concussions
8. ☐Co-Dependency
9. ☐Communication/ Relationship skills
10. ☐Crisis Intervention
11. ☐Depressive Disorders
12. ☐Dissociative Disorders
13. ☐DWI Assessments/ Treatment
14. ☐Eating Disorders
15. ☐Emotional Trauma
16. ☐Family Therapy/ Parenting
17. ☐Forensic Evaluations
18. ☐Gay/Lesbian Issues
19. ☐Grief/Bereavement
20. ☐HIV/AIDS
21. ☐Impulse Disorders
22. ☐Intellectual/ Developmental Disorders
23. ☐Life balance/ Personal Growth
24. ☐Marital Relations/Divorce
25. ☐Neuropsychology
26. ☐Obsessive-Compulsive Disorder
27. ☐Obesity/Weight Mgt.
28. ☐Personality Disorder
29. ☐Posttraumatic Stress Disorder
30. ☐Psychological Assessments
31. ☐Schizophrenia/ Psychoses
32. ☐School Issues
33. ☐Self-Injury
34. ☐Sexual/Physical Abuse

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35. ☐Sexuality/Sexual Dysfunction
36. ☐Somatoform Disorder/Chronic Pain
37. ☐Sports Mindfulness/ Training
38. ☐Substance Abuse
39. ☐Other (Specify): _____

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

<u>Opportunities to Volunteer or Become More Engaged</u>:

___ 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: _____
___ Lead a 30-minute virtual "Shot of Espresso Wellness Break" on a self-care strategy:_____
___ 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 Free Counseling (you'll be paid to deliver short-term counseling through MHA thanks to COVID-related funding)
___ 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
___ Facilitate focus group discussion

Visit www.mhaofcc.org and click on link for writeable PDF version. Completed applications may be scanned and emailed to atowner@mhaofcc.org (payment of fees can be made online) or mailed to 3701 Latrobe Drive, Suite 140, Charlotte, NC 28211. Any questions? Call 704-365-3454 ext. 223.

MHA Directory of Mental Health Professionals – Attestation Form

(Each mental health professional listed on the *MHA Online Directory of Mental Health Professionals* 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 America 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 America 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:*** _____

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