



National Resource Center for Participant-Directed Services (NRCPS) PROGRAM MEMBER APPLICATION

Thank you for your interest in becoming a program member at the NRCPS. Please note that program membership is open only to state level agencies that administer or seek to administer a participant-directed program. Please contact us at membership@participantdirection.org to determine whether you qualify.

PROGRAM INFORMATION

State Agency Name: _____

Web address: _____

Does your agency currently administer a participant-directed program? YES NO

If no, please briefly describe your agency's plans to develop a participant-directed program:

Please provide more information about your participant-directed program(s):

Program Name: _____ Start year: _____

Population(s) served: _____

Approximate number of participants served: _____

Funding mechanism:

Medicaid State Plan

State Revenue Only

Medicaid Waiver

Other, please describe _____

Please indicate the program's model of participant direction

Employer Authority only

Employer & Budget Authority

What model of financial management services (FMS) does your program utilize?

(Please select all that apply)

Fiscal/Employer Agent

Agency with Choice

Please identify your FMS provider(s): _____

Please tell us how you learned about the NRCPS:

Does your state level agency administer more than one participant-directed program? Please provide information about additional participant-directed programs on Attachment A.

What is your primary reason for becoming a member?

AGENCY REPRESENTATIVES INFORMATION

Please provide contact information for the two state level agency employees who will serve as the agency representatives and primary contacts for your program’s membership.

Agency Representative

Name & Title: _____

Work Address: _____

City, State Zip: _____

Phone: _____

Email: _____

Primary areas of responsibility: _____

Agency Representative

Name & Title: _____

Work Address: _____

City, State Zip: _____

Phone: _____

Email: _____

Primary areas of responsibility: _____

PAYMENT INFORMATION

Please select a payment option:

CHECK – Make checks payable to Trustees of Boston College, Memo: NRCPDS membership

Please mail payment to: Patti Krusz, Fiscal Specialist

314 Hammond Street

Chestnut Hill, MA 02467

INVOICE - We will mail an invoice to the financial representative listed below.

Please contact our Membership Specialist Molly Hurt Morris at 617-552-1663 or membership@participantdirection.org with any questions regarding this application.

Financial Contact:

Please provide contact information for your agency’s financial representative whom we may contact with any questions regarding payment.

Name & Title: _____

Work Address: _____

City, State Zip: _____

Phone: _____

Email: _____

TERMS OF PROGRAM MEMBERSHIP

Membership begins immediately upon approval of your application and lasts until June 30, 2012. As of July 1, 2011 program member dues are **\$695** for a 12 month membership. **If you are joining after September 30, 2011 your dues rates will be prorated, as follows:**

Join Dates:	Join Dates:	Join Dates:
10/1/11 – 12/31/11	1/1/12 – 3/31/12	4/1/12 – 6/30/12
\$521.25	\$347.50	\$173.75

The NRCPPDS membership dues structure is subject to change on an annual basis.

Membership is a program membership, not an individual membership. *Distinct agencies within the same state must apply separately.* Program membership is only open to state agencies that administer or seek to administer participant-directed programs.

An agency program member may withdraw from membership at any point during the year. However, dues are nonrefundable.

The applicant state agency will pay the program member dues within 90 days of invoice. If no payment is received after 90 days, program membership will be suspended until payment is received.

Please return application form to:

Molly Hurt Morris, Membership Specialist
 NRCPPDS, Boston College
 314 Hammond Street
 Chestnut Hill, MA 02467
Membership@participandirection.org
 Fax: 617-552-1975

It will take approximately 2 weeks to process your application. The two agency representatives and financial contact will be notified via e-mail once your membership has been accepted.

Please contact our Membership Specialist Molly Hurt Morris at 617-552-1663 or membership@participandirection.org with any questions regarding this application.

Attachment A

ADDITIONAL PROGRAM INFORMATION

Program Name: _____ Start year: _____

Population(s) served: _____

Approximate number of participants served: _____

Funding mechanism:

Medicaid State Plan

State Revenue Only

Medicaid Waiver

Other, please describe _____

Please indicate the program's model of participant direction

Employer Authority only

Employer & Budget Authority

What model of financial management services (FMS) does your program utilize?

(Please select all that apply)

Fiscal/Employer Agent

Agency with Choice

Please identify your FMS provider(s): _____

Program Name: _____ Start year: _____

Population(s) served: _____

Approximate number of participants served: _____

Funding mechanism:

Medicaid State Plan

State Revenue Only

Medicaid Waiver

Other, please describe _____

Please indicate the program's model of participant direction

Employer Authority only

Employer & Budget Authority

What model of financial management services (FMS) does your program utilize?

(Please select all that apply)

Fiscal/Employer Agent

Agency with Choice

Please identify your FMS provider(s): _____

Please contact our Membership Specialist Molly Hurt Morris at 617-552-1663 or membership@participantdirection.org with any questions regarding this application.