

Eastpointe

Beacon Center/Southeastern Regional LME-Waiver WORK GROUP/COMMITTEE APPLICATION FORM

APPLICATION INFORMATION

Please indicate which Work group or Committee you are applying for:

Clinical Advisory Committee _____ Credentialing _____ Cultural Competency _____
Implementation Meetings _____ Provider Council _____ Quality Management Committee _____

Representative's Name for Work group/Committee seat: _____

Position in the Agency: _____

Credentials (License, Certification, etc.): _____

Agency Name: _____

Is your agency a CABHA? Yes _____ No _____

Does your agency currently have an IPRS State Funded Contract with Eastpointe, Southeastern Regional or The Beacon Center? Yes _____ No _____

Disability Group(s) your agency serves: MH _____ DD _____ SA _____

How long have you been employed by your current agency?

What service(s) does your agency provide: Basic Benefits _____ Enhanced Services _____

Residential Services: Adult _____ Child _____

If your agency provides Enhanced Services please indicate which services:

Mental Health/Substance Abuse Services

Ambulatory Detox Services _____ Assertive community Treatment Team _____

Child and Adolescent Day Treatment _____ Child Residential Level II _____ Child Residential Level III _____

Child Residential Level IV _____ Community Support Team _____ Diagnostic Assessment _____

Facility-Based Crisis Program _____ Intensive In Home _____ Mobile Crisis Management _____

Medically Supervised/ADATC Detoxification/Crisis Stabilization _____ Multi-Systemic Therapy (MST) _____

Non-Hospital Medical Detoxification _____ Outpatient Opioid Treatment _____ Partial Hospitalization _____

Psychosocial Rehabilitation _____ Substance Abuse Comprehensive Outpatient Treatment Program _____

Substance Abuse Intensive Outpatient Program (SAIOP) _____

Substance Abuse Medically Monitored Community Residential Treatment _____

Substance Abuse Non-Medical Community Residential Treatment _____

If your agency provides Enhanced Services please indicate which services:

CAP-MR/DD Services

Adult Day Health _____ Behavioral Consultant _____ Crisis Respite _____ Crisis Services _____

Day Supports _____ Home and Community Supports _____ Home Supports _____

Personal Care Services _____ Residential Supports _____ Respite _____

Specialized Consultative Services _____ Supported Employment _____ Vocational Support _____

Counties that your agency provides services in: _____Bladen _____ Columbus _____Duplin

_____ Edgecombe _____ Greene _____ Lenoir _____ Nash _____ Robeson _____ Sampson

_____ Scotland _____ Wayne _____ Wilson

Please provide your contact information:

Phone Number:

Agency Address:

City:

State:

Zip Code:

Email Address:

PLEASE INDICATE WHY YOU ARE INTERESTED IN SERVING ON THE COMMITTEE BELOW

SIGNATURES

Applicant Signature:

Date Completed:

Email your completed application to KarenSalacki@thebeaconcenter.net