



## LRMHA Industry Membership Application

### GENERAL INFORMATION:

Provider/Agency Name(s): \_\_\_\_\_

Name of Primary Contact Person & Role in Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_ Preferred Contact Method: \_\_\_\_\_

Number of Sites/Locations: \_\_\_\_\_

MHR Services in which your agency participates: \_\_\_\_\_

**DUES:** Industry Members shall pay \$250 a month to maintain current membership status. Dues should be mailed to P.O. Box 1048 Amite, LA 70422 by the 10<sup>th</sup> of every month. Members can pay monthly or annually.

**AUTHORIZATION:** I authorize LOUISIANA RURAL MENTAL HEALTH ALLIANCE to officially release my name/agency name if required while conducting the business of this organization or as legally required.

**AGREEMENT:** By agreeing to become a LOUISIANA RURAL MENTAL HEALTH ALLIANCE member, I agree to adhere to the LRMHA membership commitment, which is signed and attached below, and understand membership may be terminated for violation and adequate reasons by the Board of Directors.

**MEMBERSHIP COMMITMENT:** In order to be a member of LOUISIANA RURAL MENTAL HEALTH ALLIANCE, I agree to the following:

- Maintain accreditation by a national accrediting body and have been accredited for at least two years prior to applying.
- Maintain licensing standards for all agency programs.
- Notify LRMHA of license change status within 48 hours.
- Attest that the agency follows all current regulations in the Medicaid Behavioral Health Manual.
- Report of all convictions and/or pending charges.
- Advocate for the best interest of the clients entrusted in my program.
- Exhibit acceptable and professional language and behavior to all clients and those in the program.
- Membership dues must remain current.

If at any time LRMHA feels the above standards have been violated or receives a complaint regarding your agency, LRMHA Board of Directors reserves the right to review the alleged violation to determine continued membership status.

I attest that the above information is true and correct and is for the purpose of consideration for membership in the LRMHA. I agree that my agency will abide by and support the mission of LRMHA and its membership commitment requirements. I also agree to pay monthly dues to LRMHA to maintain continuous membership status and receive information from the Executive Director and Board of Directors.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you have any questions, please contact Katie Corkern at 985-474-0624 or [kcorkern@lrnha.com](mailto:kcorkern@lrnha.com).**

### Submit Application

**Via Mail**

Louisiana Rural Mental Health Alliance  
P.O. Box 1048  
Amite, LA 70422

or

**Via Email**

Katie Corkern  
[kcorkern@lrnha.com](mailto:kcorkern@lrnha.com)

*Internal Use Only: LRMHA Board of Directors Reviewed and Voted \_\_\_\_\_ on this Membership Application on \_\_\_\_\_.*