



## 2015 PROVIDER MEMBERSHIP

### NEW MEMBER

You can also complete this form online at  
[www.opra.org/join](http://www.opra.org/join)

#### Reminders and Details

- Ohio Provider Resource Association engages in lobbying, and **under federal law, 10% of membership dues are not deductible as a business expense.**
- OPRA's membership year is from January 1 through December 31.
- The dues structure described herein is applicable solely to the 2015 membership year. Revisions may affect the dues structure for following years.
- Please return all original pages of this form to OPRA. Thank you!

#### Organization Information

These details populate OPRA's records for your organization, and will provide the content for your organization's Member Directory listing.

Organization \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, ST, ZIP \_\_\_\_\_

County \_\_\_\_\_

Main Phone \_\_\_\_\_

Website Address \_\_\_\_\_

☐ For-Profit      OR      ☐ Non-Profit      OR      ☐ Public/County Board Affiliate

# of Full-Time Employees, including all locations: \_\_\_\_\_

Total # of Employees, including all locations: \_\_\_\_\_

☐ The **physical address** for this organization is the same as the mailing address above.

If the physical address for the organization is **different** from the mailing address, please note below.

Physical Address \_\_\_\_\_

City, ST, ZIP \_\_\_\_\_

Please list all other names and/or acronyms by which your organization is known, and/or subsidiary entities which your organization owns that fall under this membership. If none, please enter "none."

\_\_\_\_\_

How were you referred to OPRA? – which individual at what organization told you about OPRA?

\_\_\_\_\_

### **OPRA Representative**

This is your organization's liaison to OPRA: all types of business-/membership-related communication (reminders, invoices, etc.) from OPRA will be sent to the attention of this individual.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

☐ The **mailing address** for this individual is the same as for the organization as listed above.

If the mailing address for the organization's OPRA Representative is **different** from the organization's mailing address, please note below.

Mailing Address \_\_\_\_\_

City, ST, ZIP \_\_\_\_\_

### **Web Access**

Please create a User ID and Password, so that you may access members-only areas of the OPRA website. At your first login, you may change your password to something only you know by entering your User ID, clicking on "Forgot my Password," then on "Login." You will be emailed about how to reset the Password.

User ID \_\_\_\_\_ Password \_\_\_\_\_

*There are no formatting restrictions or requirements for either User ID or Password.*

### **Organization Representative**

This is your organization's "public face:" this individual is your organization's main contact in the Member and Service Provider Directories. This person may or may not be the same individual as the OPRA Representative listed above.

☐ This is the **same individual** as the person listed as the OPRA Representative above.

If the Organizational Representative is **different** from the OPRA Representative, please note below.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

☐ The **mailing address** for this individual is the same as for the organization as listed above.

If the mailing address for the Organization Representative is **different** from the organization's mailing address, please note below.

Mailing Address \_\_\_\_\_

City, ST, ZIP \_\_\_\_\_

## **Other Organizational Personnel**

### **Lead HR Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

### **Lead Policy Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

### **Lead Program Direction Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

### **Lead IT Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

### **Lead Supported Employment Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

### **Lead Day Services Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

### **Lead Nursing Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

### **Lead Finance Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

### **Lead Marketing/Development Contact**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Email \_\_\_\_\_

Please continue to the next section:  
**Funding Sources & Services Provided**

## **Funding Sources & Services Provided**

***Please copy the table below if you serve more counties than there are blanks.***

Select each county where you provide services. Then, for each county, enter the number of individuals with DD receiving services by funding source.

### **NOTES:**

- ① Include individuals with DD receiving waiver services paid for by Medicaid.
- ② Include individuals with DD receiving services through the SELF Waiver paid for by Medicaid.
- ③ Include individuals with DD receiving services through the TDD Waiver paid for by Medicaid.
- ④ Include individuals with DD receiving county-funded services who are not receiving waiver services.
- ⑤ Include individuals with DD receiving day, vocational, or supported employment services.
- ⑥ Include individuals with DD receiving services funded by private pay, Medicaid, mental health, children's services boards, vocational and supported employment, etc.

**Do NOT include services for non-DD individuals!**

<b># of Individuals Served by County &amp; Funding Source</b>									
<b>County</b>	ICF/IID ①	Licensed IO Waiver ①	Non- Licensed IO Waiver ①	Level I Waiver ①	SELF Waiver ②	TDD Waiver ③	County- Funded (non- Medicaid) ④	Adult Day Services/ Employment ⑤	Other ⑥
<b>Subtotal:</b>									

If you included any individuals in the "Other" column, please specify the funding source per # of individuals:

Source:		# of Individuals Funded:	
Source:		# of Individuals Funded:	
Source:		# of Individuals Funded:	
Source:		# of Individuals Funded:	

### **Services Provided**

How many individuals **with DD** receive the following services through your organization? If your organization doesn't provide a listed service, please enter "0."

<b>Service</b>	<b>Provided?</b>		<b># of Individuals Served</b>
Adult Day Support	Y	N	
Adult Family Living	Y	N	
Community Respite	Y	N	
Emergency Assistance - Level 1 Only	Y	N	
Environmental Accessibility Adaptations	Y	N	
HCBS Transportation	Y	N	
Home-Delivered Meals	Y	N	
Homemaker Personal Care	Y	N	
Hospice	Y	N	
Housing	Y	N	
Institutional Respite	Y	N	
Interpreter Services	Y	N	
Non-Medical Transportation	Y	N	
Nursing (TDD)	Y	N	
Nutrition Services	Y	N	
Personal Emergency Response System	Y	N	
Remote Monitoring and/or Equipment	Y	N	
Residential Respite	Y	N	
SELF Waiver	Y	N	
Shared Living (formerly known as Adult Foster Care)	Y	N	
Social Work	Y	N	
Specialized Medical Equipment and/or Supplies	Y	N	
Support Brokerage Under SELF Waiver	Y	N	
Supported Employment Community	Y	N	
Supported Employment Enclave	Y	N	
Vocational Habilitation	Y	N	

### **Other Services Provided**

How many individuals **with or without DD** receive the following services through your organization? If your organization doesn't provide a listed service, please enter "0."

Service	Provided?		# of Individuals Served
Aging	Y	N	
Alcohol & Other Drugs Addiction	Y	N	
Autism	Y	N	
Child Welfare	Y	N	
County-Board-Only Funded	Y	N	
Home Care and/or Transition	Y	N	
Medicaid Card	Y	N	
Mental Health	Y	N	
Other	Y	N	
Please describe: _____			
_____			
_____			

### **Age Groups Served**

What age group(s) does your organization serve?

☐ Children only

☐ Children & Adults

☐ Adults only

### **Total Individuals Served**

How many distinct, separate individuals with DD does your organization serve?

\_\_\_\_\_

### **Total Locations**

How many locations under the organization serve individuals with DD?

\_\_\_\_\_

Please continue to the next section:

### **Membership Dues**

## Membership Dues

The dues structure described herein is applicable solely to the 2015 membership year. Revisions may affect the dues structure for following years.

1. Please record your organization's EGR for the next calendar year below.

***In figuring your Estimated Gross Revenue, do NOT include revenue from fundraisers, United Way, gifts, and donations. If your organization provides DD services to non-DD populations, you only need to include the revenue from your DD business.***

\$ \_\_\_\_\_

Estimated Gross Revenue for the next Calendar Year

2. Compare your EGR to Revenue Ranges in the table to the right, and then record your Dues Amount Owed below.

\$ \_\_\_\_\_

Dues Amount Owed

Revenue Ranges	Dues Amt Owed
Above \$10 Million	\$10,000
Above \$5 Million	\$5,000
Above \$3 Million	\$3,000
Below \$3 Million	\$1,500
Below \$1 Million	\$1,000
Independent Providers	\$100

3. You may select one of the following three payment plans for your Dues Payments.

- **Annual.** Your annual dues payment is due on or before March 15.
- **Semi-Annual.** Your 1<sup>st</sup> semi-annual dues payment is due on or before March 15. Your 2<sup>nd</sup> semi-annual dues amount will be invoiced by the end of June.
- **Quarterly.** Your 1<sup>st</sup> quarterly dues payment is due on or before March 15. Successive quarterly dues amounts will be invoiced by the end of each following quarter.

4. Based on the details above, please complete the following:

Payment Schedule	Payment Now Due	Balance Going Forward
<input type="checkbox"/> Annual	\$ _____	- 0 -
<input type="checkbox"/> Semi-Annual	\$ _____	\$ _____
<input type="checkbox"/> Quarterly	\$ _____	\$ _____

☐ Please add/confirm all listed personnel on all appropriate OPRA list servs. The OPRA Representative understands that an OPRA staff member may be in touch to confirm subscriptions and to inquire about any additional subscriptions for other employees at the organization. The OPRA Representative also consents to the organization's listing as an OPRA member on any/all published materials.

***Please have the OPRA Representative listed on Page 2 sign below.***

I certify that the information on this form is current, accurate, and complete.

Printed Name: \_\_\_\_\_

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

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