ALAMANCE CASWELL LOCAL MANAGEMENT ENTITY

PROVIDER DIRECTORY FORM

IF YOU HAVE A STATE FUNDED CONTRACT WITH ACR LME AND HAVE MORE THAN ONE SITE, PLEASE COMPLETE ONE FORM FOR EACH SITE.

Agency Name:

Physical Address:

Mailing Address:

Phone Number:

Fax Number:

TTY #:

Hotline/First Responder #:

Website:

Program Director/E-Mail Address:

Referral Contact:

Program History/Philosophy: **(may attach agency brochure)**

Service(s) Provided:

Population(s) Served:

- ☐ **Child Mental Health** ☐ **Adult Mental Health**
- ☐ **Child Dev. Disability** ☐ **Adult Dev. Disability**
- ☐ **Child Substance Abuse** ☐ **Adult Substance Abuse**
- ☐ **Other (i.e., deaf community, Spanish speaking, etc.)**

Please specify:

Hours of Operation:

Licensing/Accreditation:

Contract Status: ☐ **State funded contract with AC LME** ☐ **Medicaid MOA**

Submit completed form to:
AC LME, ATTN: Carmen Morrow
319-A N. Graham Hopedale Road, Burlington NC 27217
FAX: 336-513-4422
Email: cmorrow@acmhddsa.org