



Texas Association of Rural Health Clinics



P.O. Box 14547, Austin Texas 78761

512-873-0045/Fax 512-873-0046

New Member Application

Date: _____

(for corporate or association members, see next page)

Clinic Membership:

Rural Health Clinic: _____ County: _____

Type of Clinic: Hospital-Based: Independent: Certified: Yes No Date Certified: _____

Address: _____ City: _____ Zip: _____

Designated Representative: _____ Title: _____

Phone: _____ Fax: _____ E-mail: _____

(Required in order to receive publications)

If Hospital-Based, name of hospital: _____

If Independent, indicate clinic ownership: _____

New benefit for clinics available January 1, 2010
Joint membership in both Texas Association of Rural Health Clinics and National Association of Rural Health Clinics
at a savings of \$200! Payment can be made by check or credit card.

Types of Clinic Membership: (check one)

Regular Membership:

Single independent or hospital-based certified rural health clinic

Joint \$500

TARHC \$300

NARHC \$400

The following section is important! It allows us to accurately represent our membership on key policy and legislative issues. All information will be kept confidential and no clinic specific information will be released.

Clinic Specialty: _____ Sub-Specialty: _____

Current Medicare all-inclusive rate: \$ _____/encounter

How many days per week is your RHC open for patient care? _____

Annual Encounters (total patient encounters from most recent cost report): _____

Number of Medicare encounters: _____ Number of Medicaid encounters: _____

Please indicate the type of providers by health profession and full time/part time status providing care at the RHC:

Professional Type	Specialty (if applicable)	Number of Full Time Equivalents (FTEs)
Physician		
Physician Assistant		
Nurse Practitioner		
Certified Nurse Midwife		
Clinical Psychologist		
Social Worker		

Counties in Service Area: _____

What is the population (round to the nearest 1,000) of the town where the RHC is located? _____

What is your best estimate of the population of the RHC's service area? _____

Do you participate in Medicare Advantage? Yes No

Do you participate in a state sponsored Medicaid HMO plan? Yes No

What percentage of the RHC's patient population is uninsured? _____

Corporate or Associate Membership: (check one)

Corporate \$300
Companies doing business with RHC's

Associate \$125
Individuals interested in RHC's

Individual/Organization name: _____

Designated Representative: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Company Description (25 words or less)

Thank you for your membership!

If paying by check, mail to P.O. Box 14547, Austin, TX 78761. If by credit card see below

TARHC CREDIT CARD PAYMENT

Please Print Clearly

(fax both pages to 512-873-0046)

Total Amount Paid: \$ _____ Date: _____

Name as it appears on card: _____

PERSON AUTHORIZED TO CHARGE:

First Name: _____ Last Name: _____

Card Type: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Card Number: _____ Expiration Date: _____

Card Security Code: _____ *3-digit number on back of card, 4-digit on front for AMEX*

Signature Authorizing Charge: _____

Email Address: _____

Telephone Number: (____) _____

BILLING ADDRESS

Please enter the following information exactly as it appears on your credit card statement

Address: _____

City: _____ State: _____ Zip: _____

Payment cannot be processed unless all information is provided.