Texas Association of Rural Health Clinics

P.O. Box 203878, Austin Texas 78720 512-873-0045/Fax 512-873-0046

Membership Application

(for corporate or association members, see next page)

Date:________________

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:____

Benefit for new or current clinic members:
with completion of this application, joint membership in both Texas Association of Rural Health Clinics and National Association of Rural Health Clinics at a savings of $250! Payment can be made by check or credit card.

Types of Clinic Membership: (check one)

	Joint $500	**TARHC $300**	**NARHC $450**
Regular Membership: Single independent or hospital-based certified rural health clinic	☐	☐	☐

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	☐ Associate $125
Companies doing business with RHC's	Individuals interested in RHC's

Individual/Organization name: ______________________________

Designated Representative:______________________________

Address:____________________ City:____________________ Zip:____________

Phone:________________ Fax:______________ E-mail:____________________

Company Description (25 words or less)

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Thank you for your membership!

If paying by check, mail to P.O. Box 203878, Austin, TX 78720. If by credit card see below

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TARHC CREDIT CARD PAYMENT

Please Print Clearly

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.