



# 2012 Membership Application

**NARHC**  
 2 East Main Street  
 Fremont, MI 49412  
 Toll Free: 866.306.1961  
 Fax: 866.311.9606  
 Website: [www.narhc.org](http://www.narhc.org)

**Why join?** Joining the NARHC is an investment in the future of the RHC program. NARHC advocates at the federal and state level for policies, grant opportunities, and legislation that benefit Rural Health Clinics and the patients they serve. Through conferences, educational workshops, teleconferences, list serve forum, web site, legislative updates, and quarterly newsletters NARHC gets you the most up-to-date information.

## SECTION A: GENERAL INFORMATION

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

1.	Contact Person's Name:		
2.	Organization/Hospital Name:		
3.	Clinic Name <i>(if applicable)</i> :		CMS Clinic ID #: _ _ _ _ _
4.	Mailing/Billing Address:		
5.	Phone:		FAX:
6.	Contact's E-mail Address:		
7.	Membership Status:	<input type="checkbox"/> Renewal	<input type="checkbox"/> New Member
8.	Dues:	Mail your application & payment to: <b>NARHC, 2 East Main Street, Fremont, MI 49412</b>	
Membership Type: <input type="checkbox"/> \$200.00 New RHC Clinic – <i>less than two years</i> <input type="checkbox"/> \$450.00 Independent RHC <input type="checkbox"/> \$450.00 Provider-based RHC <input type="checkbox"/> \$115.00 For Each Additional Clinic <input type="checkbox"/> \$400.00 Governmental or Association (circle which) – non-voting* <input type="checkbox"/> \$550.00 Corporate or Consultant (circle which) – non-voting*  <i>* Only RHC Membership Types may vote.</i>			
<b>Method of Payment:</b> <input type="checkbox"/> Check <input type="checkbox"/> Credit Card (Visa or MasterCard Only!)		<b>Credit Card:</b> Credit Card Number: _____ Expiration Date: _____ Three digit security code: _____ Name on Card: _____ Card Billing Address: _____	
<b>Total Amount Paid: \$</b> _____			

**The following Clinic Information is important!** It allows NARHC to accurately represent its membership on key policy and legislative issues. All information will be kept confidential and no clinic specific information will be released. If your clinic is part of an Affiliation Network, **please copy these pages** and complete a Section B for each rural health clinic affiliate member.

**SECTION B: CLINIC INFORMATION**

1.	Clinic Name:			CMS Clinic ID #: _____
2.	Clinic Address:			
3.	Clinic Contact No.:	Tele:	Fax:	E-mail:
4.	Clinic Specialty:	Sub-Specialty:		
5.	Date of Initial RHC Certification:			
6.	Current Medicare all-inclusive rate:	\$	/encounter	
7.	Annual Encounters (total patient encounters from most recent cost-report			
	No. of Medicare encounters:	No. of Medicaid encounters:		
8.	How many days per week is your RHC open for patient care?			
9.	Please indicate the type of providers by health profession and full time/part time status providing care at the RHC:			
	<b>Professional Type</b>	<b>Specialty (if applicable)</b>	<b>Number of Full Time Equivalents (FTEs)</b>	
	Physician			
	Physician Assistant			
	Nurse Practitioner			
	Certified Nurse Midwife			
	Clinical Psychologist			
	Social Worker			
	Chiropractor			
10.	What is the population (round to the nearest 1,000) of the town where the RHC is located?			
11.	What is your best estimate of the population of the RHC's service area?			
12.	Do you participate with a Medicare HMO or PPO plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13.	Do you participate with a State sponsored Medicaid HMO plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14.	Does your clinic accept new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			
15.	What percentage of the RHC's patient population is uninsured?			

**Release of Information:**

NARHC's mailing list has been requested for purchase by third parties. Our mailing list consists of members, listserve requests, purchased CMS list and participants from conferences. *NARHC has the right to refuse the sale of this list upon their discretion.* NARHC does *not* share email addresses. Because we value your opinion as a member, please indicate below your desire.

- Yes, I would like my contact information passed along to valuable third parties.
- No, I do not want my contact information passed along.

**Note:** If no box is checked, NARHC will assume it is fine to release your information.