NATIONAL ASSOCIATION OF Community Health Centers

HCCNetwork Membership Application

HCCNetwork Membership: This category is a non-voting category of membership, open to any incorporated health center controlled network entity* that supports the mission of NACHC. Dues are based on the total number of patients cumulatively served by the HCCN's owners, members, and provider participants as applicable. ** Qualifying HCCN entities must be at least 51% owned and/or controlled by federally qualified health centers.*

Three EASY ways to apply:

MAIL
Mail application and payment to:
NACHC Membership Department
7501 Wisconsin Avenue, 1100W
Bethesda, MD 20814

E-MAIL
E-mail application form with credit card information to: **membership@nachc.org**

FAX
Fax application form with credit card information to: **(301) 347-0459**

SECTION 1. HCCNETWORK INFORMATION

Name of Organization

Key Contact

Address

City **State** **Zip Code**

Telephone **Fax** **E-mail**

Organization Website **Social Media Handle:** ☐ Facebook ☐ Twitter ☐ Instagram ☐ LinkedIn

Sign up as a **NACHC Health Center Advocate** on www.hcadvocacy.org and receive relevant advocacy and policy communications.

☐ Register me as a NACHC Health Center Advocate!

☐ Yes, I would like to receive the one free annual subscription to *Community Health Forum* magazine, unless I advise differently.

SECTION 2. DUES & PAYMENT INFORMATION (Payment *MUST* be received with application)

Dues are based on the total number of patients cumulatively served by the HCCN's owners, members, and provider participants as applicable. (Check whichever is applicable).

- ☐ **Level 1 (Less than 70,000 patients): $2,500/year**
- ☐ **Level 2 (70,001 – 100,000 patients): $3,000/year**
- ☐ **Level 3 (100,001 – or more patients): $5,000/year**

PAYMENT ENCLOSED $_____

☐ Check is enclosed payable to NACHC

I authorize NACHC to charge my: ☐ MasterCard ☐ Visa ☐ American Express

Name as it appears on card (Please Print)

Credit Card Number **Expiration Date**

Card Holder's Signature **Date**

SECTION 3. HCCNETWORK DEMOGRAPHICS

Please assist NACHC in better serving your HCCN's needs and in planning for future products and services by completing the following demographic survey.

A. HCCNetwork Profile

Number patients served annually by owners, members and/or participating providers: _____

Number of annual patient encounters: _____

Number of HCCN Staff: _____

Number of owners, members, and/or participating partners: _____

Year the HCCN was formed: _____

B. HCCNetwork Characteristics: (Check all that apply)

☐ Horizontal*	☐ Vertical**	☐ Urban	☐ Rural
☐ For-Profit	☐ Non-Profit	☐ Statewide	☐ Bi-State and/or Multi-State
☐ Limited Liability Partnership	☐ Limited Liability Company		

*Horizontal Integration: integration that occurs among collaborators at the same level of care (e.g., all primary care providers)

** Vertical Integration: Integration that occurs among collaborators at different levels of care (e.g., hospitals, tertiary care centers, and primary care providers).

C. Additional Contact Information

Identify and list four (4) key health center leaders, including Board Chair.

BOARD CHAIR	**Telephone**	**E-mail**
HUMAN RESOURCE DIRECTOR	**Telephone**	**E-mail**
CHIEF MEDICAL OFFICER	**Telephone**	**E-mail**

OR Select Appropriate Title: ☐ CLINICAL DIRECTOR ☐ MEDICAL DIRECTOR ☐ OTHER _____

CHIEF FINANCIAL OFFICER	**Telephone**	**E-mail**

OR Select Appropriate Title: ☐ FISCAL OFFICER ☐ FISCAL DIRECTOR ☐ OTHER _____