



# Texas Association of Rural Health Clinics

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



## Membership 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: \_\_\_\_\_

**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)

#### Regular Membership:

Single independent or hospital-based certified rural health clinic

Joint \$600

TARHC \$300

NARHC \$450

**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 Equivalent (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 203878, Austin, TX 78720. If by credit card see below

**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.**