



FOR NACHC USE ONLY:

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7200 Wisconsin Avenue, Suite 210 • Bethesda, MD 20814 • ☎ 301.347.0400 • 📠 301.347.0459

**HEALTH CENTER CONTROLLED NETWORK ASSOCIATE
MEMBERSHIP APPLICATION**

- HCCN Associate Membership:** This category is a non-voting category of membership, open to any separately incorporated health center controlled network entity* that is not otherwise eligible for NACHC Organizational membership and 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.

Dues: (Check whichever is applicable.)

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

* Qualifying HCCN entities must be at least 51% owed and/or controlled by federally qualified health centers.

Name of Organization: _____

Key Contact Person: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Fax: () _____

E-Mail Address: _____ Web: _____

Membership Dues Payment Information:

Method of Payment: Check enclosed in the amount of \$ _____
(Mail payment to the address listed above.)

Please charge the credit card number listed below:

Type of Credit Card: American Express MasterCard Visa

Card Number: _____

Expiration Date: _____ **Amount:** _____

Name on Card: _____

Card Holder's Signature: _____

Confirmation of Membership will be mailed within two weeks of receipt of membership dues payment. However, member benefits begin immediately upon receipt of dues payment. For questions, please contact the Membership Department at (301) 347-0400.

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NATIONAL ASSOCIATION OF
Community Health Centers

HEALTH CENTER CONTROLLED NETWORK ASSOCIATE MEMBER DEMOGRAPHICS

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

Approximate number of patients served annually by owners, members, and/or participating providers:

Approximate number of annual patient encounters: _____

Number of HCCN staff: _____

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

Year the HCCN was formed: _____

HCCN Characteristics: (check all that apply)

- | | | | |
|--|--|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Horizontal* | <input type="checkbox"/> Vertical** | <input type="checkbox"/> Urban | <input type="checkbox"/> Rural |
| <input type="checkbox"/> For-Profit | <input type="checkbox"/> Non Profit | <input type="checkbox"/> Statewide | <input type="checkbox"/> Bi-State |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> 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).**

Additional Contact Information

Board Chair: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax: _____

(Please include a separate sheet for additional HCCN staff contacts.)