

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.*

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)

- | | | | |
|--|--|------------------------------------|--|
| <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 and/or Multi-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).

C. Additional Contact Information

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

BOARD CHAIR	Telephone	E-mail
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HUMAN RESOURCE DIRECTOR	Telephone	E-mail
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CHIEF MEDICAL OFFICER	Telephone	E-mail
OR Select Appropriate Title: <input type="checkbox"/> CLINICAL DIRECTOR <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> OTHER _____		

CHIEF FINANCIAL OFFICER	Telephone	E-mail
OR Select Appropriate Title: <input type="checkbox"/> FISCAL OFFICER <input type="checkbox"/> FISCAL DIRECTOR <input type="checkbox"/> OTHER _____		