

HEARTLAND RURAL HEALTH NETWORK, INC.
1200 West Avon Boulevard, Suite #109, Avon Park, Florida 33825
Office: (863) 452-6530 Fax: (863) 452-6882

Membership Application

(Please print this application and mail to the above address or fax to (863) 452-6882)

Name: _____

Organization:

Business Address: _____

City: _____ State _____ Zip _____

Mailing Address: (if different than above)

City: _____ State _____ Zip _____

Email Address:

Telephone Numbers: _____ (Business)

_____ (cell phone)

_____ (Fax)

Counties Served: _____

Other Locations: (Please list the addresses and phone and fax numbers of other locations)

Business Address: _____

City: _____ State _____ Zip _____

Telephone Number: _____

Business Address: _____

City: _____ State _____ Zip _____

Telephone Number: _____

Business Address: _____

City: _____ State _____ Zip _____

Telephone Number: _____

Sector Representation:

Please identify what sector in our community that you would represent.

Consumer: _____ Business: _____ Education: _____ Local

Government _____ Health Care Provider: _____

Other: (Please identify) _____

If Health Care Provider, please check the area that is most representative of the services provided by you or your organization:

Acute Care Hospital _____

Behavioral Health _____

Chiropractic Care _____

Community Based Services for the Elderly _____

Dialysis Services _____

Emergency/Trauma Medical Services _____

Federally Qualified Community Health Center _____

Health Education/ Health Promotion/ Preventive Health _____

Home Health Services _____

Hospice Care _____

Long Term Care Facility _____

Obstetrical Care Services _____

Outpatient Diagnostic Services _____

Physician Assistant _____

Physical Rehabilitation Services _____

Primary Care Physician _____

Public Health Services _____

Rural Health Clinic (certified) _____

Specialty Care Hospital _____

Specialty Care Physician _____

Tertiary Care Hospital _____

Other: (Please Explain) _____

Health Care Providers:

If you are a health care provider you will also need to execute a Participating Provider Agreement if you are a local area based provider or a Strategic Alliance Agreement if you are an out-of-the-area based provider. Please indicate if you have executed one of these agreements.

Yes No

Purpose & Mission of the Network:

The Heartland Rural Health Network was certified by the State of Florida in 1995 to accomplish the following objectives:

- ❖ To provide an effective continuum of care for all patients served by the Network
- ❖ To ensure the availability of a wide array of health care services either directly, by contract or through referral agreements with other providers
- ❖ To reduce patient outmigration and increase the utilization of rural hospitals and other rural health care providers

- ❖ To enhance access to high quality health care services for rural residents
- ❖ To support the rural economy and protect the health and safety of rural residents
- ❖ To ensure that quality care is efficiently delivered to all persons in rural areas
- ❖ To serve as laboratories to determine the best way of organizing rural health services

By joining the Heartland Rural Health Network I, hereby, verify that I am in agreement with the above objectives and that it is my intent to consistently support the Network in its efforts to accomplish this mission.

Name of Organization (if applicable)

Applicant Signature:

Title

Date

Heartland Rural Health Network, Inc.

Executive Director

Date