HEARTLAND RURAL HEALTH NETWORK, INC.

1200 West Avon Boulevard, Room #109, Avon Park, Florida 33825
Office: (863) 452-6530 Fax: (863) 452-6882
www.hrhn.org

MEMBERSHIP APPLICATION

Name:_____

Organization:_____

Business Address:_____

_____

Mailing Address: (if different than above)

_____

_____

E-Mail Address: _____ **Website:** _____

Telephone Numbers: _____**(Business)** _____**(Cell phone)**

_____**(Fax)**

Counties Served:_____

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

_____
Address

Phone:_____ **Fax:**_____

_____
Address

Phone:_____ **Fax:**_____

_____
Address

Phone:_____ **Fax:**_____

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

Consumer:_____ **Business:**_____ **Education:**_____ **Local Government**_____

Health Care Provider:____ **Social Service 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 _____

Mission: ***Improve the health of all rural residents.***

Vision: ***Public and private partnerships meeting rural health needs through cooperative and collaborative programs for all residents.***

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

- ◊ **To provide a 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 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