



# Indiana Primary Health Care Association

## Primary Care Provider

### 2010/11 Membership Application

Please send completed application, payment, and all requested materials to:

• **IPHCA** •  
**Attention: Member Services Specialist**  
**429 N. Pennsylvania St., Suite 333**  
**Indianapolis, IN 46204**

For questions, please call Stephanie Suddeth at 317-630-0845  
[www.indianapca.org](http://www.indianapca.org)

#### **About your Indiana Primary Health Care Association**

**Our Mission:** To champion the development and delivery of accessible, community-driven quality health care.

**Our Vision:** A barrier-free, high quality health care system that is affordable, available, accessible, appropriate, and acceptable.

#### **Our Beliefs and Values:**

1. Health care is a right, not a privilege.
2. Grassroots advocates are crucial to community-supported health care.
3. Comprehensive, integrated, and coordinated primary health care encompasses medical, dental, behavioral health, and enabling services.
4. The Community Health Center (CHC) model, to which the consumer's voice is integral, provides for an outcome-based and patient-focused health care home.
5. IPHCA equips leaders to advance health care goals and objectives.



2010/11 IPHCA Membership Application
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Applicant Name: _____	2010/11 Membership Year
Organization: _____	April 1, 2010- March 31, 2011
Mailing Address: _____	<u>Membership Type</u>
_____	<b>Primary Care Provider</b> (please check type)
City: _____ State: _____ Zip: _____	_____ Consumer- Governed _____ State Funded CHC _____ Associate Provider
Telephone: _____	<input type="radio"/> Membership types described on page 3
FAX: _____	<input type="radio"/> Member dues and policy information on page 8
Email: _____	
Website: _____	
Date Center Opened: _____	
Date First Received State Funding: _____	
Date First Received Federal Funding (if applicable): _____	

<u>Annual Budget</u> (Total operating budget, except for in-kind)	<u>Annual Dues</u>
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\$ 0-250,000	\$ 250
\$ 250,000-500,000	\$ 500
\$ 501,000-1,250,000	\$ 1,250
\$ 1,250,001-2,000,000	\$ 2,000
\$ 2,000,001-3,500,000	\$ 3,500
\$ 3,500,001-5,000,000	\$ 5,000
\$ 5,000,001-7,500,000	\$ 7,500
\$ 7,500,001-10,000,000	\$10,000
\$10,000,001 +	\$12,000

<p align="center"><b>Primary Care Provider</b> (Please select a payment option)</p> <p>_____ Full annual payment _____ Two semi-annual payments _____ Four quarterly payments</p> <p align="center">IPHCA will invoice members for quarterly and semi-annual payments</p>
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<b><u>PAYMENT INFORMATION</u></b>		
Please include payment with application and required documents.		
_____ My check is enclosed and made payable to "IPHCA" in the amount of: \$ _____		
This is a (circle one):      quarterly                      semi-annual                      annual payment		
_____ Please charge my (circle one):      VISA                      MASTERCARD		
Card number: _____		
Expiration Date: _____		
Name as it appears on card (please print): _____		
Address card is registered to: _____		
_____		
Cardholder's Signature: _____		

**PRIMARY CARE PROVIDER MEMBERSHIP TYPES**

- **CONSUMER GOVERNED PRIMARY CARE PROVIDER MEMBERSHIP**
  - Non-profit or tax exempt organization committed to IPHCA's mission
  - Actively engaged in providing primary health care
  - Governed by a Board of Directors comprised of more than 50% of consumer/community membership
  - Provides primary health care services to indigent persons on a sliding or reduced fee scale
  
- **STATE FUNDED COMMUNITY HEALTH CENTER PRIMARY CARE PROVIDER MEMBERSHIP**
  - Governed by a Board of Directors, Advisory Committee, or Advisory Board with less than 30% consumers
  - Receives operational funding through monies designated for community health centers by the State of Indiana.
  
- **ASSOCIATE PRIMARY CARE PROVIDER MEMBERSHIP**
  - Any non-profit or tax exempt organization or rural health clinic committed to the purposes of this Association
  - Offers primary health care services to indigent persons on a sliding or reduced fee scale
  
- Please note: As a condition of membership, contact information will be published in our membership directory and on the IPHCA website. Employee contact information may also be published in the membership directory, and/or on the IPHCA website.
- A membership is not active until approval of the application by the IPHCA Board of Directors. IPHCA reserves the right to reclassify a member to a different category when appropriate. The member will receive a letter regarding acceptance from IPHCA in 6-8 weeks.



REQUIRED DOCUMENTS

The following documents are required of New Primary Care Provider members upon application.

- **Most Currently Completed Fiscal Year-End Financial Statement**
- Current and Complete Listing of Clinical, Mental Health, and Dental Providers By Position; Full Time Equivalent (FTE) as of 1/1/10. Please Include Current Vacancies
- Bylaws
- List of Services Provided
- Current Copy of Sliding or Reduced Fee Scale

*\*\*Please clearly mark the name on each required document. These documents should be submitted with the application.*

- Aggregate data gleaned from the required documents will be used for lobbying and education efforts for key stakeholders. Individual CHC information obtained from the required documents will not be shared without permission from the individual health center. IPHCA's membership list may not be sold or shared with any non-member entity or non-member individual.
- Information gathered through any participation or interactions as an IPHCA member must be treated as confidential and considered proprietary in nature.
- By signing below, you indicate your support for the work of the Indiana Primary Health Care Association and a desire to become a supporting member.
- Contact the Member Services Specialist at (317) 630-0845 with any questions.

Signed: \_\_\_\_\_ Title: \_\_\_\_\_

Dated: \_\_\_\_\_

**MEMBER INVOLVEMENT**

(Please complete if you are applying for any Provider membership.)

*Member involvement is vital to the success of IPHCA. Please complete the following sections.*

Designate one Organization Representative to the IPHCA General Assembly Meeting	
Name:	Title:
Address	Telephone:
	Fax:
City: State: Zip:	E-mail:
GRASSROOTS ADVOCACY COORDINATOR	OTHER PERTINENT STAFF
Name:	Name:
Telephone:	Telephone:
Fax:	Fax:
Email:	Email:
Should receive Legislative Update?	Should receive Member Update and Legislative Update?

**Standing Committees of the Board**

- Executive Committee
- Membership Committee
- Finance Committee
- Personnel Committee
- Nominating Committee
- Health Policy Committee

**Forums to the Board**

- Clinical Leadership Forum
- Consumer Involvement Forum
- Federally Qualified Health Center (FQHC) Forum
- Indiana State Community Health Centers Forum

*Forums make recommendations to the Board of Directors related to the scope of the Forum. Appointments to all committees and forums are made by the Chair and approved by the Board.*

**MEMBER INVOLVEMENT**

Indicate any individual(s) who will serve as your representative at the IPHCA Forums.  
(If you have multiple sites, please complete one sheet for each site.)

Site Location: \_\_\_\_\_

<b>CLINICAL LEADERSHIP FORUM</b>	<b>STATE-FUNDED CHC FORUM</b>
Name:	Name:
Telephone:	Telephone:
Fax:	Fax:
E-mail:	E-mail:
Name:	Name:
Telephone:	Telephone:
Fax:	Fax:
E-mail:	E-mail:
<b>FQHC FORUM</b>	<b>CONSUMER INVOLVEMENT</b>
Name:	Name:
Telephone:	Telephone:
Fax:	Fax:
E-mail:	E-mail:
Name:	Name:
Telephone:	Telephone:
Fax:	Fax:
E-mail:	E-mail: