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| **MEMBERSHIP APPLICATION** | | | | | | | | | | |
| **ORGANIZATIONAL MEMBER INFORMATION**  (Please complete a separate form for each clinic.) | | | | | | | | | | |
| Membership category *(Please indicate)* | | | | * CARHC clinic membership | | | | * Affiliate   non-clinic membership | | |
| Clinic Name: | | | | | | | | | | |
| Name of Health System or District Affiliation (if applicable): | | | | | | | | | | |
| Name of Hospital or Organization (if applicable): | | | | | | | | | | |
| **Clinic or Organization** | Physical Street Address: | | | | | | | | | |
| City: | | | State: | ZIP Code: | | | | County: | |
| Phone: | | | Fax: | Email: | | | | Website: | |
| Mailing Address (if different): | | | | | | | | | |
| City: | | | State: | ZIP Code: | | | | Clinic CMS Number: | |
| RHC category (Please check) | | | * Independent | | | * Provider-Based | | | * Affiliate |
| Ownership category (Please check) | | | * Nonprofit | | | * For Profit-Corporation | | | * Government-Federal |
|  | | | * For Profit-Partnership | | | * Government-Local |
|  | | | * For Profit-Individual | | |  |
| Clinics Only: | | | Annual RHC Encounters: | | RHC Certification Year: | | | | # RHC Employees (Not FTE): | |
| Affiliates: Please provide information about your interest in RHCs. (This may be used in your directory listing.) | | | | | | | | | | |
| Member Contacts: Name(s), Emails, and Direct Phone Number. (We encourage multiple contacts in your organization.) (Please indicate the primary contact and billing contact.) | | | | | | | | | | |
| **ANNUAL DUES** | | | | | | | | | | |
| $300 | | CARHC Member Clinic | | | | | | | | |
| $100 | | Additional clinic Membership (Please complete a separate Membership Application for each additional member, additional clinics must be within the same health system) | | | | | | | | |
| $350 | | Affiliates (Non-Clinic Member) | | | | | | | | |
| Payments can be made by logging into your Member’s Portal at [www.CARHC.org](http://www.CARHC.org). You may also opt to email this application to [Info@CARHC.org](mailto:Info@CARHC.org) and fill out the payment info. Or you may mail your application and payment to **CARHC, 5817 N. Maruyama, Fresno, CA 93723.** If you have any questions, call us at **559-706-8226** or email to [**Info@CARHC.org.**](mailto:Info@CARHC.org) | | | | | | | | | | |
| Credit Card Payment:  VISA  MasterCard  Discover Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Name On Card:** | | | | | | **Card Number:** | | | | |
| **Exp. Date:** | | | | | | **Security Code:** | | | | |
| **Billing Address:** | | | | | | | | | | |
| **SIGNATURE** | | | | | | | | | | |
| Signature of applicant: | | | | | | | | | Date: | |

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