MISSOURI HOSPITAL ASSOCIATION
INSTITUTIONAL MEMBERSHIP APPLICATION

Submit to:
MISSOURI HOSPITAL ASSOCIATION
P.O. BOX 60
JEFFERSON CITY, MO  65102-0060

DATE _______________________

Name of Institution: ___________________________________________________________

Street Address: ________________________________________________________________

Mailing Address: _______________________________________________________________

City/State/Zip: _________________________________________________________________

Phone: ____________________  Fax: ____________________

Name of Chief Executive Officer: ________________________________________________

Title and credentials (M.D./MHA/FACHE/Mr./Ms.): _________________________________

E-mail: __________________________

Type of Facility:

_____ General Acute Care  _____ Rehabilitation

_____ Psychiatric  _____ Other (Specify: _______________________________

Type of Ownership: (Check all that apply.)

_____ Not-For-Profit  _____ Public  _____ State  _____ County

_____ Investor-Owned  _____ Federal  _____ City  _____ District

Management contract (duration and with whom): ___________________________________

Federal tax I.D. number: ________________  Number of licensed beds: ________________

Number of physicians employed: ______________________

Is the facility a Medicare provider? _____ Yes  _____ No  If yes, provider number: _____________

Is the facility part of a health system or network(s)? _____ Yes  _____ No

If so, describe ________________________________________________________________
Total gross expenses for last fiscal year (including depreciation and interest) $________________________

Does the facility have a home health agency or any primary care clinics, nursing homes or other ambulatory care sites? ______ Yes ______ No

If so, describe: ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

Are expenses for these sites included in the facility’s expenses? ______Yes ______ No

If no, indicate expenses for these sites: _______________________________________

________________________________________________________________________

Check accreditation(s)/certification(s):

_____ DHSS  _____ CARF  _____ CIHQ  _____ DNV  _____ AAHHS

_____ The Joint Commission  _____ Medicare  _____ Medicaid

List other memberships the institution holds or other associations to which the institution belongs: __________

________________________________________________________________________

________________________________________________________________________

Does the institution have an auxiliary? ______Yes ______ No

Please attach a list of senior staff and their titles to facilitate efforts to assist the institution’s management team, and provide the names of the facility’s board members below.

Chairman/President: _________________________________________________________

Vice President: _____________________________________________________________

Secretary: __________________________________________________________________

Treasurer: __________________________________________________________________

Others: ___________________________________________________________________

This institution understands that institutional members of the Missouri Hospital Association are voting members and that this application is subject to approval by the Missouri Hospital Association Board of Trustees.

Signed: ________________________________

Title: ________________________________

Date: ________________________________

Date Received: _________________________  Date Approved: _________________________