GATEWAY TO CARE COLLABORATIVE
APPLICATION FOR MEMBERSHIP

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PLEASE FAX THE COMPLETED FORM AND A 1-PAGE DOCUMENT ABOUT THE ORGANIZATION TO **713.785.3077** OR MAIL TO THE ABOVE ADDRESS.

The organization/agency listed below wishes to become a Member ☐ Affiliate ☐ of the Gateway to care Collaborative and is in support of its purpose and mission of ensuring access to health care for uninsured and underinsured citizens in a seamless service delivery system in the Greater Houston/Harris County/Texas Gulf Coast Region. The organization/agency listed below agrees to follow the *Core Values of the Collaborative*. (See additional requirements at Gatewaytocare.org under the Collaborative tab)

MEMBER/AFFILIATE ORGANIZATION LEADERSHIP INFORMATION

Organization / Agency: _____

Organization/Agency Executive Director/CEO: _____

Executive Director/CEO Email Address: _____

Organization Website Address: _____

Total Number of Employees: _____

Total Number of Partners/Members Your Organization Collaborate with Annually (Estimate). In essence, What is Your Organizations Total "Reach": _____

MEMBER/AFFILIATE REPRESENTATIVE(S) TO THE GTC COLLABORATIVE (If Different Than Person Listed Above)

Organization Representative(s) assigned to attend GTC Collaborative Meetings:

_____

_____

Representative(s) Title(s): _____

_____

Representative(s) Email Address (es): _____

_____

ORGANIZATION CONTACT INFORMATION

Organization Main Address: _____

City, State, Zip: _____

Office Phone: _____

Cell Phone: _____

Fax: _____

My above listed organization focuses on the following areas and agrees to assist the Gateway to Care Collaborative in developing and effectuating strategies to bring health care resources and services to improve the overall health of all residents in our city, county and Region (circle as many as applies):

_____ Health Service Access	_____ Community Health Centers
_____ Program Evaluation	_____ Policy (Legislation & Funding)
_____ Provider Networking	_____ Outreach/Education/Advocacy
_____ Health Insurance Innovation	_____ Wellness and Prevention
_____ Culture of Health	_____ Health Disparities
_____ Children & Families	_____ Elderly and Caregivers

Other _____

Please List Your Organization Main Focus (Area(s): _____

Authorizing Signature: _____ Date: _____

Office Use Only

By my signature I certify that this application for membership was presented to the Collaborative and membership was approved on the date of my signature.

_____ _____

GTC Executive Director Date