



Women's Health
And Family Planning
Association Of Texas



2010 PROVIDER MEMBERSHIP APPLICATION

SECTION A. CONTACT INFORMATION

Primary Contact*: _____ Title: _____
 Company: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Ext: _____ Fax: _____
 Email: _____ Company Website: _____

**Individual who will receive all Provider mailings from WHFPT, be listed as the primary contact on the WHFPT Website and Membership Directory, serve as the Provider Member's Voting Delegate, and receive complimentary Professional Membership status.*

SECTION B. 2010 PROVIDER DUES

WHFPT Provider dues are based on your organization's 2010 annual family planning budget for *all clinic sites affiliated with the primary location*. Annual dues are calculated at 1/3 of 1% of your family planning operating budget. Regardless of budget size, a minimum of \$500 and a maximum of \$25,000 are due annually.

Dues Formula:

- A. Total amount of Title V Family Planning allocation (including co-pay) _____
- B. Total amount of Title X allocation _____
- C. Total amount of Title XX allocation (including co-pay) _____
- D. Total Title XIX Medicaid reimbursement (including WHP) _____
- E. Total Earned Income (self-pay and third party payers) _____
- F. Total family planning budget (sum of A, B, C, D, & E) _____
- G. Provider Member Dues (F multiplied by .0033) _____
- H. Minimum due = \$500 / Maximum due = \$25,000 _____
- I. Provider Member Dues with 2% Discount (*dues paid in full by 1/31/10*) _____

SECTION C. PAYMENT INSTRUCTIONS

- Please mail payment (in full or first installment) along with the completed forms. Please make copies of all documents for your records prior to mailing.
- My check is enclosed for payment in full (*dues paid in full by the date indicated qualify for a 2% discount*)
- I would like to pay in four quarterly installments* (*dues paid on a quarterly basis are due on April 1st, July 1st, and October 1st*)
- I would like to pay in monthly installments* (*dues paid on a monthly basis are due no later than the 5th of each month*)

** Invoices will be emailed to the authorized primary contact.*

SECTION D. AUTHORIZED SIGNATURE

Signature of Person authorized to complete this form: _____

Please print name: _____ Date: _____

2010 PROVIDER VERIFICATION FORM

This form is used to report your agency's information. This information will be included in the WHFPT Directory, Website, and used for referral services. Please include the completed forms with your Provider Membership Application and mail to: WHFPT, 905-A West Oltorf St., Austin, TX 78704.

SECTION A. PRIMARY CONTACT INFORMATION

Primary Contact: _____ Title: _____

Direct Telephone and Ext.: _____ Mobile: _____

***WHFPT respects your privacy. We will not sell, rent, or distribute your email address or telephone numbers to any outside person or organization. WHFPT intends to use this information to communicate membership related notices and benefits, as well as conference information.**

SECTION B. PROGRAM INFORMATION

Do not list this program in the WHFPT Membership Directory or the "Find a Provider" section of the WHFPT Website.

1. Number of family planning clients served by your location in 2009: _____
2. Dominate Ownership Status (choose one):
 - Independent/Freestanding Organization
 - Division of a Hospital
 - Division of a Medical School
 - Division of a Federally Qualified Health Center
 - Division of a Health Department
 - Division of a Community Action Agency
 - Planned Parenthood Affiliate
 - Other (please explain): _____
3. Incorporation Status:
 - Non Profit
 - For-Profit
 - Government
4. Total number of paid staff: _____
5. Total of full-time staff equivalents: _____
6. Total number of volunteer staff: _____
7. Other state/national membership organizations to which you belong (please list): _____

SECTION C. LOCATION INFORMATION (to provide accurate referrals)

1. Major Metropolitan Area you serve (please list only one city): _____
2. Counties Served:
3. Cities Served:
4. Zip Codes:

SECTION D. OTHER SERVICES OFFER BY YOUR AGENCY

Please check all that apply:

- Female/Male Sterilization
- Infertility Services
- Natural Family Planning
- Client Advocacy
- Other (please explain): _____
- Pregnancy Termination
- Treatment of STDs
- Colposcopy
- Speakers Bureau
- Special services for adolescents
- Special services for men
- Midlife & Post-Menopausal Care
- Community Education Program

SECTION E. FUNDING SOURCES FOR YOUR AGENCY

Please check all that apply:

- Title V
- Title XIX
- Grant Writing
- Title X
- Earned Income
- Medicaid's WHP
- Title XX
- Fundraising

SECTION F. GOVERNMENT REPRESENTATIVES

House Representatives from your area: _____

Senator from your area: _____

SECTION G. EMPLOYEE & VOLUNTEER MEMBERSHIP

All paid and non-paid staff of your organization are eligible for Professional Membership with the Women's Health & Family Planning Association of Texas. These individuals will be listed in the WHFPT Professional Membership Directory, have access to the *members only* section of the WHFPT Website, and receive all membership communications.

SECTION H. WHFPT EMAIL ALERT LIST

Please list all others (both employees and volunteers) in your organization you wish to receive alerts, news, and special announcements.

NAME	TITLE	EMAIL	PHONE
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NAME	TITLE	EMAIL	PHONE
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NAME	TITLE	EMAIL	PHONE
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NAME	TITLE	EMAIL	PHONE
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