



**Texas Organization of Rural & Community Hospitals**

**HOSPITAL MEMBERSHIP APPLICATION**

Date: \_\_\_\_\_

**Hospital Name** \_\_\_\_\_

**Administrator Representing Hospital** \_\_\_\_\_

Street Address \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-Mail \_\_\_\_\_

**Ownership/Type Categories: (check applicable category below)**

- Governmental/Public**  
 District: Supported by a local hospital district  
 Authority: Supported by a local hospital authority  
 City: Supported by the city  
 County: Supported by the county

**Not-for-Profit** (\_\_\_\_\_ church-related; \_\_\_ other, including NFP Corp)

**For-Profit** (\_\_\_ investor-owned; \_\_\_ corporation; \_\_\_ partnership)

Number of Licensed Beds \_\_\_\_\_

Number of Staffed Beds \_\_\_\_\_

DSHS Region/Zone \_\_\_\_\_

**Management Type: (check applicable)**

- Independent Administration  
 Corporate: Part of a larger system  
 Managed: Operated by an outside company  
 Leased: Under an ownership agreement

JCAHO Certified? \_\_\_\_\_

Does hospital have:

Rural Health Clinic? \_\_\_\_\_

Home Health Care? \_\_\_\_\_

Designation:

Sole Community? \_\_\_\_\_

Medicare Dependent? \_\_\_\_\_

Critical Access? \_\_\_\_\_

By \_\_\_\_\_

**General acute care hospital less than 150 beds in size**

Dues Categories:

**A.** Annual Gross Revenue  
Less than \$10 million: \$1650

**B.** Annual Gross Revenue  
\$10 to \$50 million: \$2750

**C.** Annual Gross Revenue  
More than \$50 million: \$3300

**Membership Fee Enclosed: \$** \_\_\_\_\_

Dues Year: January 1 - December 31

**Make check payable to TORCH; Mail to P. O. Box 203878, Austin, Texas 78720**

# Texas Organization of Rural & Community Hospitals

## CREDIT CARD PAYMENT FORM

Please Print Clearly

Total Amount Paid: _____		Date: _____		
Name as it appears on card: _____				
<b>PERSON AUTHORIZED TO CHARGE:</b>		<i>Company and/or Individual Name</i>		
First Name: _____		Last Name: _____		
Card Type:	<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> AMERICAN EXPRESS	<input type="checkbox"/> DISCOVER
Card Number: _____		Expiration Date: _____		
Card Security Code: _____				
Signature Authorizing Charge: _____				
Email Address: _____				
Telephone Number: _____				

### BILLING ADDRESS

Please enter the following information exactly as it appears on your credit card statement

Address: _____		
City: _____	State: _____	Zip: _____

Payment cannot be processed unless all information is provided.

You may fax the completed form to (512) 873-0046