



## THE Consortium Membership Form



Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Please invoice me for the following Consortium membership type:

- SHIP Hospital: FREE
- CRHC Member Hospital: \$1200
- Non-CRHC Member Hospital: \$1500
- CRHC Member Clinic: \$500
- Non-CRHC Member Clinic: \$800
- Clinic-NET Contributing Affiliate (\$200 level or higher): \$600

Primary Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Other Consortium Contacts (to receive email updates and information):

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

### **I am interested in learning more about the following Consortium services:**

#### *HIT Adoption & Implementation Solutions*

- Assessment, roadmap & workflow analysis
- Implementation "hand-holding" services
- Vendor assistance (negotiation, contract review, ombudsman, etc.)
- Workflow assistance to utilize systems effectively

#### *Group Purchasing Solutions*

- Hardware and software infrastructure needs
- Remote 24/7 help desk IT support

#### *HIPAA Privacy & Security Solutions*

- HIPAA Compliance Package (including Policies & Procedures)
- HIPAA on-site security risk assessment
- IT security framework training for IT professionals

#### *Federal HITECH Incentive Funding Services*

- Personalized assistance with calculating and understanding the Federal Stimulus Incentive

Contact Tracy McDonald at [tm@coruralhealth.org](mailto:tm@coruralhealth.org) or 303-832-7449 with questions. Fax (303-832-7496) or email ([tm@coruralhealth.org](mailto:tm@coruralhealth.org)) completed form.

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