



## GATEWAY TO CARE COLLABORATIVE APPLICATION FOR MEMBERSHIP

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Gateway to Care

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PLEASE FAX THE COMPLETED FORM TO 713.785.3077 OR MAIL TO THE ABOVE ADDRESS.

The organization / agency listed below wishes to become a  Member  Affiliate of the Collaborative and is in support of its mission of ensuring access to health care for uninsured and underinsured citizens in a seamless service delivery system in the Greater Houston Area. Member organizations have a vote and commit to be represented at 60% of the meetings of the Collaborative. Affiliated organizations do not have a vote and are usually engaged with one or more of the task areas associated with the Collaborative and are expected to attend meetings only on an occasional basis as appropriate to their area of interest.

Organization / Agency: \_\_\_\_\_

Organization/Agency Representative: \_\_\_\_\_

Title: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

As the representative for the organization/agency identified above, I wish to participate on the following coalition tiers:

- |                               |   |
|-------------------------------|---|
| _____ Service Access          | _____ Community Health Center Development |
| _____ Program Evaluation      | _____ Policy (Legislation & Funding)      |
| _____ MIS Integration         | _____ Provider Networking                 |
| _____ Outreach                | _____ Health Insurance Innovation         |
| _____ Wellness and Prevention |   |

Authorizing Signature: \_\_\_\_\_

*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.*

\_\_\_\_\_  
Executive Director

\_\_\_\_\_  
Date