Central and West Central Minnesota Healthcare Preparedness Coalition
Healthcare Facility Membership Signature Form

(this form is for hospitals, long term care, assisted living, hospice, clinics, and Community Health Boards/Local Public Health use only)

Healthcare Facility/Agency Information

Legal Facility Name: ____

List of other facilities that fall under this facility – i.e. LTC/Clinics:

____

____

Facility Phone number: ____

Command Center Phone #: ___________________ Command Center Email: _______________________

Address: ____

Facility/Agency Administrator Contact Information

☐ The Facility Administrator contact information is accurate and there are no changes.

Name: ____ Position Title: _________________________________

Primary Phone: __________________________________ Email: ____

Primary Facility/Agency Emergency Preparedness Representative

☐ The Emergency Preparedness Representative contact information is accurate and there are no changes.

Name: ____ Position Title: _________________________________

Primary Phone: __________________________________ Email: ____

Alternate 1 Facility/Agency Emergency Preparedness Representative

☐ The Alternate 1 contact information is accurate and there are no changes.

Name: ____ Position Title: _________________________________

Primary Phone: __________________________________ Email: ____

Alternate 2 Facility/Agency Emergency Preparedness Representative (only complete if applicable)

☐ The Alternate 2 contact information is accurate and there are no changes.

Name: ____ Position Title: _________________________________

Primary Phone: __________________________________ Email: ____

DATE COMPLETED/UPDATED: ____

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By signing this document, ____, will participate in the Central or West Central Minnesota Healthcare Preparedness Coalition (based upon geographic location) in the following ways (check all that apply):

Facility Contact Information (see page 1)

☐ I have reviewed the facility contact information on page one and acknowledge that the information provided is up to date and/or have made the appropriate revisions. I agree to provide the coalition staff any updated information if changes to page one are necessary prior to the end of the year reporting.

Bylaws

☐ I have reviewed the bylaws which are posted in the coalition website (link below) and by checking this box, I agree to be member of the coalition as described in the bylaws.

Memorandum of Understanding (MOU)

☐ I have reviewed the MOU which is posted in the coalition website (link below) and by checking this box, I agree to collaborate and assist other healthcare facilities/agencies as resources allow during times of disaster, as described in the MOU.

Funding Agreement

☐ I understand my health care facility/agency may be eligible for reimbursement from the Hospital Preparedness Program (HPP) grant, for projects and programs related to WCMHPC development as described in the budget. Reimbursement guidelines can be found in the coalition website at:

☐ I will not use reimbursed Federal funds to influence Federal agencies.

☐ I have provided coalition staff with a copy of my facilities IRS W-9 form and understand this document needs to be completed prior to receiving reimbursement. The W-9 form can be found at: ** All documents can be found on the coalition website: www.cwchealthcarecoalitions.org

This document will be held by the coalition in perpetuum. The members are requested that if there are changes to the points of contact - these changes are sent to the Regional Coordinator.

Name Printed:

Title:

Signature:

____ Date: