Heartland Health Alliance

HEARTLAND HEALTH ALLIANCE
REQUEST FOR INFORMATION FOR MEMBERSHIP

Facility Name_____

Facility Address_____

1. POPULATION		
Primary Service Area population. (Where 70% of discharges are from. May use either zip code or county population)		
Number of PCP's within your community	Employed	Not Employed
2. PRIMARY SERVICE AREA ACUTE INPATIENT DISCHARGE MARKET SHARE		
% of total hospitalized patients from Primary Service Area discharged from your hospital		
3. FINANCIAL CONSIDERATIONS (LATEST 2 FISCAL YEARS)		
	Last FY	**Previous FY**
A. Operating margin (%)		
B. Total Revenue		
4. HOSPITAL BED CAPACITY		
Number of inpatient beds		
5. MEDICAL STAFF		
Physicians by Specialty -Does not include visiting specialists.		

Heartland Health Alliance

6. EXISTING RELATIONSHIPS (ex. management agreement, CAH network, GPO, etc.)

7. PARTICIPATION IN STATE & FEDERAL QUALITY PROGRAMS		
☐	MBQIP	Other (Please list):
☐	HCAHPS	
☐	Hospital Engagement Network	
☐	UNMC Fall Collaborative	
☐	Bryan CAH Quality Project	

Please describe why your facility is interested in joining the Heartland Health Alliance:

Please provide key individuals who would participate in Heartland Health Alliance Activities:

Title	Name	Email	Phone
CEO			
CFO			
CNO/DON			
Quality			
IT			
HR			

Signature & Title

Date