CONTINUUM OF CARE MEMBERSHIP APPLICATION

Section I - Participating Member Information: *(All Fields In This Section Are Required)*

Participating Member Facility Name:			Primary Contact Name:
Street Address *(No P.O. Boxes Please)*:		Ste.:	Primary Contact Title:
City:	State:	Zip code:	Primary Contact Phone Number:
Member Phone Number:			Primary Contact Email:
Website:			

Start Date: _____ (Start Date may not precede the received date of a signed copy of an application.)

Section II - Member Primary Service: Please choose one below *(Required)*

☐ Adult Day Care Center	☐ Health Plan/HMO/PPO	☐ Physician(s)
☐ Ambulatory Care Center	☐ Healthcare Corporate Office	☐ Prison/Correctional Health
☐ Assisted Living	☐ Healthcare Management Svc Org	☐ Public Health Department
☐ Behaviora Health - Inpatient	☐ Home Health Care Agency	☐ Rehabilitation Center
☐ Behavioral Health - Outpatient	☐ Home Infusion	☐ Religious Institute
☐ Charity	☐ Hospice – Home Care	☐ Retail Pharmacy
☐ Closed Door Pharmacy	☐ Hospice – Inpatient	☐ Skilled Nursing (# of Beds ____)
☐ Community Health Center	☐ Imaging Center	☐ Student/Employee Health Svc
☐ Cont Care Retire Community (CCRC)	☐ Independent Living	☐ Substance Abuse Treatment Center
☐ Dentistry	☐ Mail Order Pharmacy	☐ Surgery Center
☐ Dialysis Center	☐ Meals on Wheels	☐ Veterinary
☐ DME & Supply Dealer	☐ Medical Association	☐ Wellness Facility/Fitness Ctr
☐ First Responder	☐ Oncology Center	☐ Healthcare-Other:
☐ Freestanding Healthcare Laboratory	☐ Pharmacy	

Section III - Sponsor/Parent Information:

Sponsor Name (Sponsoring Premier Owner/Purchasing Group): Avera Health	Direct Parent Name (parent company, if different from Sponsor):
Sponsor Entity Code: SD2017	Direct Parent Entity Code:

Participating Member Relation to Direct Parent[1] ***(If No Direct Parent, Indicate Participating Member Relation to Sponsor):***

☐ Owned ☐ Leased ☐ Managed ☒ Affiliated (Not Owned, Leased or Managed)

Required to be completed by Sponsor: **Sponsor has reviewed the governmental exclusionary lists as required by Premier's policies and Participating Member does not appear on any such list: ☒ Agree ☐ Disagree**

Section IV - Unique Industry Identifiers:

GLN (Global Location Number):	DEA (Drug Enforcement Agency) #:	HIN (Health Industry Number):

[1]Definitions for the types of Member Relations:

OWNED: A facility is considered to be owned if the Sponsor or Parent directly or indirectly holds (1) a majority of the equity or corporate Membership interests in the facility or the power to appoint a majority of such facility's governing board or (2) a significant interest (which may be less than a majority of the total equity) sufficient to enable operational control and such facility is willing to designate Premier Healthcare Alliance, L.P. as its primary group purchasing organization.

LEASED: A facility is considered to be leased if it is leased and operated by its Sponsor or Parent.

MANAGED: A facility is considered to be managed if the Sponsor or Parent manages such facility in whole or in part (including at a minimum, the supplies purchasing function).

AFFILIATED: A facility is considered to be affiliated if the Sponsor or Parent formally sponsors the facility for participation in Premier's group purchasing organization, but does not own, lease or manage it.

TERMS CONDITIONS AND SIGNATURES

By signing below, Participating Member agrees that:

- Participating Member has read and understands the Premier Group Purchasing Policy ("the Policy") and agrees to comply with the Policy as revised by Premier from time to time.
- Participating Member will use Premier Healthcare Alliance, L.P. ("Premier") as its primary group purchasing organization.
- Participating Member will use all products and supplies it purchases under group purchasing agreements of Premier and, if applicable, the Sponsor named on the first page of this agreement ("Sponsor") solely for its own operations and will not re-sell any such products or supplies (except to the extent Participating Member is a DME provider or retail pharmacy that is purchasing from suppliers who offer pricing to DME providers and/or retail pharmacies with the expectation that products will be re-sold).
- Participating Member (and Participating Member's agents, employees and representatives) shall keep confidential Premier's and Sponsor's proprietary and confidential information and shall not disclose such information to any third parties other than Premier's affiliates, Sponsor or Participating Member's employees with a need to know (who have been made aware of this provision by Participating Member and agree to comply with it). Such confidential information includes without limitation Premier's and Sponsor's plans, reports, proposals, agreements, organizational documents, clinical studies, software, pricing information, and contract catalogs (printed and electronic). Participating Member's obligation to maintain the confidentiality of such information shall remain in effect continuously throughout the period of Participating Member's membership in Premier and for a period of five (5) years thereafter.
- Participating Member will sign (or in the case of Multi-Facility Systems, will cause each of the facilities listed in Exhibit D to sign and return to Premier) the Facility Authorization and Vendor Fee Agreement attached as Exhibit A. The signed original of the Facility Authorization and Vendor Fee Agreement should be returned to Premier as soon as possible and a copy retained by Participating Member (and each facility in a Multi Facility System) for its records. Notwithstanding approval of Participating Member's application to become a member in Premier, Participating Member (and in the case of Multi-Facility Systems, each facility listed in Exhibit D) will not have the right to participate in Premier's and Sponsor's group purchasing programs until the Facility Authorization and Vendor Fee Agreement has been signed and returned to Premier. Execution of the Facility Authorization and Vendor Fee Agreement is required for compliance with the regulatory safe harbor for group purchasing organizations under the Federal Medicare Anti-Fraud and Abuse Statute, codified at 42 C.F.R. § 1001.952(j).
- In the event Participating Member is subject to applicable open records laws (such as a federal, state or municipal agency) which may require Participating Member to release confidential or proprietary information of Premier or Sponsor, Participating Member agrees to promptly notify Premier and/or Sponsor, as applicable, of any request under such laws for the release of such information. Further, Participating Member shall cooperate in good faith with Premier and Sponsor and use its best efforts to assist Premier and Sponsor in preventing the release of such information to the extent consistent with applicable law.
- Participating Member hereby acknowledges that the discounts available under Premier and Sponsor contracts may be exclusive and that its access to, or acceptance of, any incentives or rebates under separate programs may impact the discounts available to it under Premier and/or Sponsor contracts.
- Participating Member represents and warrants that it (and its officers, directors and employees) are not listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in any federal and/or state programs. Premier and/or Sponsor may terminate Participating Member from participation in the Program immediately in the event at any point Participating Member is not in compliance with this representation and warranty. Termination is in addition to any other rights or remedies Premier and Sponsor may have at law or in equity.
- Participating Member acknowledges that rebates or discounts it may receive from vendors as part of its participation in the Premier group purchasing program are, for purposes of 42 C.F.R. Section 1001.952(h), "discounts or other reductions in price" and Participating Member is required to disclose the specified dollar value of any such discounts or reductions in price under any state or federal program which provides cost or charge-based reimbursement to such Participating Members.
- Participating Member acknowledges and agrees that by entering into this agreement the parties have not established, and do not intend to establish, a "business associate" relationship, as such term is defined under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA"). Under no circumstances will Premier request from Participating Member, nor will Participating Member provide to Premier, "protected health information," as such term is defined in HIPAA. For the avoidance of doubt, Participating Member agrees that Premier is not engaging any supplier as its downstream business associate.
- Participating Member represents and warrants that its execution and performance of this agreement does not conflict with or violate any other agreement or obligation to which Participating Member is subject or by which it is bound.
- Participating Member acknowledges and agrees that Premier, its affiliates and their respective directors, officers, employees and agents will not be liable for the acts or omissions of Premier's contracted suppliers, or for any representations or warranties made by such suppliers.
- Participating Member confirms that all information supplied by Participating Member to Premier and Sponsor is complete and accurate.
- Participating Member authorizes Premier and Sponsor to individually activate group purchasing contracts on its behalf.

If Participating Member is a Multi-Facility System, Participating Member hereby represents that it is authorized to sign this agreement on behalf of itself and each of the facilities listed in Exhibit D. In such case, Participating Member and each such facility shall be bound by the terms of this agreement.

Signature of Participating Member	Signature of Sponsor Ryan Donovan
Printed Name of Participating Member	Printed Name of Sponsor Director
Title	Title
Date	Date

Email the completed application and exhibits to kevin.jordanger@avera.org .

Participating Member Information:

Participating Member Facility Name ("Participating Member"):
Street Address *(No P.O. Boxes Please)*:
City:
State:
Zip code *(+4 if available)*:

Participating Member and Premier Healthcare Alliance, L.P. ("Premier") hereby agree as follows:

PURCHASING AGENT FOR PURPOSES OF PARTICIPATING IN GROUP PURCHASING PROGRAMS
Premier and Sponsor, if applicable, are each authorized to act as a purchasing agent for Participating Member and any child sites that are added to Exhibit D as it may be amended from time to time.

ADMINISTRATIVE FEE
Participating Member is hereby notified that vendors pay to Premier an administrative fee of three percent (3%) or less of the purchase price of goods and services such vendors provide, which may be apportioned between Premier and Sponsor pursuant to a separate agreement. In the event there are any exceptions to the foregoing statement, they will be noted in a report located in Premier's online member portal.

ANNUAL DISCLOSURE OF ADMINISTRATIVE FEES
On an annual basis, Premier shall provide Participating Member written notice of the amount of administrative fees which Premier has received from vendors with respect to purchases made by or on behalf of Participating Member.

Signature of Participating Member

Printed Name Date

Title

ACKNOWLEGED BY PREMIER HEALTHCARE ALLIANCE, L.P.
By: Premier Services, LLC,
Its: General Partner

Susan D. DeVore

Premier Authorized Signature Date

Susan DeVore, President and CEO
Printed Name, Title

Facility Name _____ DEA # _____ HIN # _____

PLEASE INCLUDE COPY OF DEA CERTIFICATE WHEN SUBMITTING APPLICATION

PHARMACY START DATE*: _____ *(*If there is an existing contract with another service provider, the start date may be delayed until after the expiration of the existing contract.)*

Please check one which applies:

☐ **ACUTE NON-RETAIL:** Acute care hospitals (including both acute and sub-acute beds) which use pharmaceuticals for their own operations, excluding operations which compete with retail trade.

☐ **NON-ACUTE NON-RETAIL:** Health facilities which have no (or few) acute care beds and use pharmaceuticals for their own operations, excluding operations which compete with retail trade. Such facilities include, but are not limited to ambulatory surgery centers, diagnostic imaging centers, rehabilitation facilities, clinics, home infusion pharmacies, and outpatient hospices.

☐ **STATE/COUNTY/MUNICIPAL GOVERNMENT ENTITIES:** 1) Non-federal government entities or agencies providing health benefits (drug) to state/county/municipal employees on a self-insured or self-funded basis. 2) Entities that meet the definition of non-profit as defined by Internal Revenue Service code 501(c)(9) that provide health benefits on a self-insure or self-funded basis via Taft-Hartley Trust Funds and is tax exempt.

☐ **RETAIL:** Retail pharmacies open to walk-in trade.

☐ **LONG TERM CARE:** A facility that provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living. Long-term care facilities include skilled nursing facilities, adult day care centers, assisting living facilities, inpatient behavioral health facilities, continuing care retirement communities and inpatient hospice facilities.

☐ **ONCOLOGY PHYSICIAN OFFICE/CLINIC:** A certified and licensed physician office/clinic and business unit that engages in the diagnosis and/or management of patients with oncology and oncology related diseases, including purchase, preparation, dispensing, administration, management, and billing of oncology and oncology related diagnostics and therapy.

- If the Participating Member participates in the pharmacy program, it will purchase all of its annual requirements for pharmaceuticals which are covered by contract awards made by the Premier Healthcare Alliance, L.P. ("Premier") pharmacy program as measured by annual dollar volume. In cases where Premier has not contracted for certain items required by Participating Member, Participating Member is encouraged to contact Premier so that those items may be added to the Premier portfolio of contracted products.
- Participating Member designates the primary wholesaler provided in this agreement to be its prime vendor for purchasing pharmaceuticals under the Pharmacy Program. Participating Member further authorizes the primary wholesaler, and secondary wholesaler, if applicable, to release all purchase data to Premier.
- Participating Member represents that all products and supplies purchased under Premier group purchasing agreements are for Participating Member's own operations, excluding operations which compete with retail trade. If Participating Member is a Multi-Facility System, Participating Member represents that all products and supplies purchased under Premier group purchasing agreements by facilities in Participating Member's system are for each such facility's own operations, excluding operations which compete with retail trade. If Participating Member competes with retail trade, Participating Member acknowledges that it will be eligible to purchase products and supplies through the Program only from Premier suppliers who offer pricing to the Participating Member with the expectation and understanding that the products will be re-sold.
- Participating Member understands that each manufacturer and each wholesaler agreement has individual terms and conditions

Former Purchasing Group: _____ Termination Date: _____

Primary Designated Wholesaler

Name _____

Address _____

City/State/ZIP _____

Secondary Designated Wholesaler

Name _____

Address _____

City/State/ZIP _____

Signature of Member's Pharmacy Director or Other Authorized Person

Printed Name _____

EXHIBIT C – CONTACT PROFILE

Please provide contact information in the table below (or in the attached Excel file) for anyone within your facility(s) interested in receiving communications from Premier. If left blank, the default contact will be the Primary Contact listed on Page 1.

Exhibit C - Contact Profile

Contact 1	**Contact 2**	**Contact 3**
Full Name	Full Name	Full Name
Title	Title	Title
Organization Name	Organization Name	Organization Name
Address	Address	Address
City, State, and Zip	City, State, and Zip	City, State, and Zip
Phone	Phone	Phone
Fax	Fax	Fax
Email	Email	Email
Contact 4	**Contact 5**	**Contact 6**
Full Name	Full Name	Full Name
Title	Title	Title
Organization Name	Organization Name	Organization Name
Address	Address	Address
City, State, and Zip	City, State, and Zip	City, State, and Zip
Phone	Phone	Phone
Fax	Fax	Fax
Email	Email	Email
Contact 7	**Contact 8**	**Contact 9**
Full Name	Full Name	Full Name
Title	Title	Title
Organization Name	Organization Name	Organization Name
Address	Address	Address
City, State, and Zip	City, State, and Zip	City, State, and Zip
Phone	Phone	Phone
Fax	Fax	Fax
Email	Email	Email

EXHIBIT D – LIST OF CHILD SITES

Please use the form attached below to list all child sites that will be receiving products and services through the Program. Participating Member will be asked to respond "Yes" or "No" to the following two questions for each child site listed on the form:

1. **Does the Participating Member have legal authority to sign and bind the child site to contracts, including the terms of this agreement?**
2. **Does the Participating Member have control over all supply chain and purchased services for the child site?**

If the answer to Question 1 is "No" the child site must complete its own, separate agreement. If the answer to Question 2 is "No" a separate Exhibit A (page 3 of this agreement) must be completed for the child site.

Exhibit D - List of Child Sites_Modifiec

By submitting Exhibit D to Premier, Participating Member certifies that the responses listed on Exhibit D are true and accurate.

Participating Member authorizes and designates its sponsor, distributor or other agent to add new child sites by submitting to Premier a list of new child sites on the attached form or by other written communication for the same purpose. Participating Member acknowledges and agrees that by making or authorizing any such future submissions of child site(s), unless expressly stated otherwise in the applicable submission, Participating Member certifies that it (1) has legal authority to sign and bind the child site(s) to contracts, including the terms of this agreement, and (2) has control over all supply chain and purchased services for the child site(s).

Signature of Participating Member

Printed Name Date

Title

Premier Rebate ACH Direct Deposit Enrollment Form

Please complete this form in order to receive Premier Foodservice, Pharmacy and Medical/Surgical rebates through Direct Deposit. Premier offers Direct Deposit so that you may receive your rebates faster, while reducing the potential for fraud.

Date: _____

Facility/Member Information:

Facility Name: _____ Entity Code (if Known): _____

Address: _____

City: _____ St: _____ Zip: _____

Authorized by:

Name: _____ Title: _____

Phone: _____ Email Address: _____

Account Information:

Bank Name: _____

Account Name: _____

ABA Routing Number (for ACH deposits): _____

Account Number: _____

Email Notifications:

Below, please list any email addresses that should receive an email notification when a rebate deposit is made to your account. Multiple email addresses can be provided for each type of rebate.

	Email Addresses:
Foodservice Rebates: ☐ Check if not applicable	
Pharmacy Rebates: ☐ Check if not applicable	
Med/Surg Rebates: ☐ Check if not applicable	

This form may be returned to Premier Membership, along with the Membership Application, by email to kevin.jordanger@avera.org. You may also fax the Premier Rebate ACH Direct Deposit Enrollment Form separately, directly to Premier Rebates, by email to PremierRebates@PremierInc.com or by fax to 605-322-4666.