



Tennessee Initiative for Perinatal Quality Care (TIPQC) Community Resource Council Application

TIPQC is dedicated to improving health outcomes for birthing people and babies throughout Tennessee. The Tennessee Initiative for Perinatal Quality Care consists of providers, patients, families, nursing/physicians, and community organizations working to develop and implement evidence-based quality improvement projects to improve care in the perinatal period. TIPQC seeks to promote meaningful change, advance health equity, and improve the quality of care through pregnancy, delivery, and beyond for all Tennessee families. This year 42 hospitals participated in TIPQC with 82% of state's births.

The TIPQC Community Resource Council aims to connect and engage nonprofits, government agencies, and other civic organizations (collectively, "Community Resource") working to meet the needs of birthing people, babies, and Tennessee Families.

Each application will be reviewed by TIPQC staff to ensure each organization meets the criteria for participation outlined below. Acceptance into the Community Resource Council does not indicate TIPQC or its affiliates, the Tennessee Department of Health, or any Tennessee hospital's endorsement of third-party services or websites.

Once we receive your completed application, we will contact you via email a determination of acceptance into the Community Resource Council. If you have any questions regarding the Community Resource Council or this application, please email Anastacia.volz@TIPQC.org.

Criteria for Participation:

- Organization should serve individuals in TN.
- Program must serve birthing people, TN Families, and/or children.
- Be willing to attend quarterly community resource council meetings.
- Allow TIPQC to use contact information, name, and logo of Community Resource on TIPQC's website and on any printed material or other medium in connection with TIPQC's Community Resource Council.



Organization/Company Information:

Organization/Company Name: _____

Street Address: _____

City, State, Zip: _____

Mailing Address (if different from above): _____

City, State, Zip: _____

Website: _____

Please select the region of TN your organization has a presence in:

West	Middle	Northeast	East	Southeast	Statewide
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Your Organization's Mission Statement:

Category of Services (check all that apply):

- | | | |
|--|---|---|
| <input type="radio"/> Education | <input type="radio"/> Childhood Development | <input type="radio"/> Pregnancy and Post-Partum Support |
| <input type="radio"/> Lactation | <input type="radio"/> Professional Membership Organization/ Association | <input type="radio"/> Family Planning |
| <input type="radio"/> Family Engagement | <input type="radio"/> Mental Health | <input type="radio"/> Health Equity |
| <input type="radio"/> Family Support | <input type="radio"/> Hospital/Providers Office | <input type="radio"/> Other (Write in):

_____ |
| <input type="radio"/> Opioid and/or Substance Use Disorder | | |
| <input type="radio"/> Care Management | | |



What goals and/or expectations do you have in partnering with TIPQC?

Organization/Company Contact Information

Primary Contact Name: _____

Primary Contact Phone: _____

Primary Contact Email: _____

Secondary Contact Name: _____

Secondary Contact Phone: _____

Secondary Contact Email: _____

Agreement and Signature:

I have my organization's authority to grant and hereby do grant TIPQC the right to use my organization's contact information, name, and logo on TIPQC's website and on any printed material or other medium in connection with TIPQC's Community Resource Council. Further, I have my organization's authority to submit this application and when accepted by TIPQC, the Agreement, and I affirm that the facts and representations set forth in this application and if accepted by TIPQC, Agreement, are true and complete. Further, I affirm my organization understands that if accepted as a Community Resource to the TIPQC Community Resource Council, any false statements, omissions, or other misrepresentations made on this application may result in my organization being dismissed from the TIPQC Community Resource Council.

Name (printed): _____

Signature: _____

Date: _____

FOR TIPQC USE

Accepted by TIPQC: Yes No Date: _____