



MEMBERSHIP APPLICATION FORM

BASIC INFORMATION

The application must be signed by an official representative authorized by the organization's governing board to sign on behalf of the organization, such as the Executive Director, CEO, or Board President.

Name of Organization
Contact Person Title
Address City/State/Zip County
Phone Fax Email
Signature Title

APPLICANT PROFILE

Organizational Information Please check category that best describes your organization:

- Community Health Center (Section 330)
Migrant Health Center (Section 329)
Health Care for the Homeless (Section 340)
Federally Qualified Health Center (no federal funding)
City or State-Funded Health Center
State or Regional Community-Based Organization Local
Community-Based Organization
Other (please specify)

Location Urban Rural

Primary Health Services Provided Please designate the services your organization provides. (On = On Site, Off = Off Site)

Note: If the applicant is an existing CHC, a copy of the latest UDS Report may be submitted in place of the following information.

On Off Primary Care Substance Abuse Diagnostic Lab/X-ray AIDS/HIV Screening
OB/GYN Preventive Optometry AIDS/HIV Outpatient Treatment/Care Disease
Pharmacy Transportation 24-hour On-call AIDS/HIV Inpatient Treatment/Care
Case Management Gerontology Screening and Control Alternative/Integrative Health Practices
Social Services Environmental Health Dental Physical Therapy
Pediatrics WIC Immunization
Health Education Nutrition

Other health/social services provided (please list):

Please check primary health services provided by age group: Perinatal Adult Adolescent Pediatric Elderly

Please list languages in which comprehensive primary care services are available:

Patient/Client Profile

What is the total number of patients served? _____ Encounters? _____

What percentage of your patients are AA & NHOPI? _____

List the ethnic composition of your AA & NHOPI patients:

Ethnicity	Number	% of Total AA & NHOPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Key Organizational Staff

Name	Phone	Email
Executive Director	_____	_____
Associate Director	_____	_____
Medical Director	_____	_____
Fiscal/Operation Director	_____	_____
Health Education Director	_____	_____
MIS Director	_____	_____
Quality Improvement Director/Staff Director	_____	_____

SELECT MEMBERSHIP TYPE

Full Membership

Open to not-for-profit, 501(c)(3), community health centers whose mission includes providing direct primary care services to medically underserved populations, living in the United States, its territories, and freely associated states. Qualifying community health centers must serve a minimum of 30% Asian Americans and Native Hawaiians and Pacific Islanders (AA and NHPI) patients **OR** a minimum of 5,000 AA and NHPI patients. The level of primary care services offered must be similar to FQHCs or FQHC look-alikes. Full members of AAPCHO nominate their representative to AAPCHO's Board of Directors. This designated individual also represents the member organization in transactions with AAPCHO. The annual full membership fee is based on a percentage (0.08622%) of applicant's total revenue as determined by the most recently completed IRS Form 990 tax filing or equivalent. Dues are capped at a maximum of \$15,000. Due upon membership approval by AAPCHO's Board of Directors.

Associate Membership

Open to not-for-profit community health centers, organizations and associations which are committed to the mission and goals of AAPCHO. Although associate members do not have a voting seat on the Board of Directors, they are encouraged to participate in all other open Board activities including attending Board meetings, committee assignments, and to participate in advocacy efforts. The annual associate membership fee is based on a percentage (0.08622%) of applicant's total revenue as determined by the most recently completed IRS tax filing or equivalent. Associate Member dues have a minimum of \$3,000 and capped at \$5,000. Due upon approval by AAPCHO's Board of Directors.

For timely application review, please ensure AAPCHO has the following:

- Completed AAPCHO Membership Application Form.
- Articles of Incorporation
- IRS statement verifying not-for-profit status or equivalent.
- Most recently completed IRS Form 990 tax filing or equivalent.
- Current mission statement.
- Most recent annual report or one-page organizational description.