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)  _____ City or State-Funded Health Center

_____ Migrant Health Center (Section 329)  _____ State or Regional Community-Based Organization Local

_____ Health Care for the Homeless (Section 340)  _____ Community-Based Organization

_____ Federally Qualified Health Center (no federal funding)  _____ 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  On    Off  On    Off  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  Nutrition
Health Education

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 & NH/PI? ____________

List the ethnic composition of your AA & NH/PI patients:

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<th>Ethnicity</th>
<th>Number</th>
<th>% of Total AA &amp; NH/PI</th>
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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 (AAs), Native Hawaiians and Pacific Islanders (NH/PIs) patients OR a minimum of 5,000 AA and NH/PI 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.