

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		Employer Identification Number (EIN) / Tax Identification Number (TIN)	
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:*

- | | |
|---|---|
| <input type="checkbox"/> Community Health Center (Section 330) | <input type="checkbox"/> City or State-Funded Health Center |
| <input type="checkbox"/> Migrant Health Center (Section 329) | <input type="checkbox"/> State or Regional Community-Based Organization Local |
| <input type="checkbox"/> Health Care for the Homeless (Section 340) | <input type="checkbox"/> Community-Based Organization |
| <input type="checkbox"/> Federally Qualified Health Center (no federal funding) | <input type="checkbox"/> 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
<input type="checkbox"/> <input type="checkbox"/> Primary Care	<input type="checkbox"/> <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> <input type="checkbox"/> Diagnostic Lab/X-ray	<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Screening
<input type="checkbox"/> <input type="checkbox"/> OB/GYN	<input type="checkbox"/> <input type="checkbox"/> Preventive	<input type="checkbox"/> <input type="checkbox"/> Optometry	<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Outpatient Treatment/Care Disease
<input type="checkbox"/> <input type="checkbox"/> Pharmacy	<input type="checkbox"/> <input type="checkbox"/> Transportation	<input type="checkbox"/> <input type="checkbox"/> 24-hour On-call	<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Inpatient Treatment/Care
<input type="checkbox"/> <input type="checkbox"/> Case Management	<input type="checkbox"/> <input type="checkbox"/> Gerontology	<input type="checkbox"/> <input type="checkbox"/> Screening and Control	<input type="checkbox"/> <input type="checkbox"/> Alternative/Integrative Health Practices
<input type="checkbox"/> <input type="checkbox"/> Social Services	<input type="checkbox"/> <input type="checkbox"/> Environmental Health	<input type="checkbox"/> <input type="checkbox"/> Dental	
<input type="checkbox"/> <input type="checkbox"/> Pediatrics	<input type="checkbox"/> <input type="checkbox"/> WIC	<input type="checkbox"/> <input type="checkbox"/> Physical Therapy	
<input type="checkbox"/> <input type="checkbox"/> Health Education	<input type="checkbox"/> <input type="checkbox"/> Nutrition	<input type="checkbox"/> <input type="checkbox"/> Immunization	

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:

Ethnicity	Number	% of Total AA & NH/PI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Key Organizational Staff

Name, Title	Email	Phone
-------------	-------	-------

Primary Member Representative

Please provide the contact information for your organization's designated Member Representative. The Member Representative is our primary contact at your organization. AAPCHO Members typically designate their CEO/Executive Director as their organization's Member Representative but have also included other staff positions such as Chief Operating Officer, Interim CEO, etc.

Direct Services (Community Programs or Clinical) Contact

Research and Data Contact

Policy and Advocacy Contact

Development and Fundraising Contact

Communications/Press Contact

Finance and Accounting Contact

Billing Contact

Additional Contacts (If different from above.)

Health Education Director

Executive Director

Associate Director

Medical Director

Fiscal/Operation Director

Quality Improvement Director/Staff Director

MIS 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.

Form 990 Information

Total Revenue (Line 12) _____

Form Year (Listed at the top right of Form 990.) _____

If a Form 990 is not available, please provide total income for most recently closed fiscal year. _____

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.