Membership Application Instructions

Complete and submit the following membership application and include the following information:

- Recent annual report &/or brochure
- Copy of latest federal grant application (if applicable)
- List of sites (with addresses and phone numbers)
- Other pertinent information about your organization

This application will be reviewed by OACHC's Membership Services Committee, which meets via teleconference. The Committee requests that a representative from the organization applying for membership be available to answer questions during the meeting if necessary. The application will then be considered for approval at the next regularly scheduled OACHC Board of Directors Meeting. An OACHC representative will contact you prior to the meeting with details.

Mail or e-mail your application and other materials to:

Ohio Association of Community Health Centers
Attn: Membership
2109 Stella Ct.
Columbus, OH 43215

Samantha Porter
(614) 884-3101
sporter@ohiochc.org

Please Note: ***Do not send payment at this time. An invoice will be sent to you upon approval of the membership application.***

Date of Application: _____

Contact Information

Organization Name: _____

UDS #: _____ Grant #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Email Address: _____

Web Address: _____

Government Districts

State Senate District: _____

State House District: _____

Congressional District: _____

Organizational Information

1. **What type(s) of organization are you classified as (check all that apply)?**

   ☐ Community Health Center ☐ Migrant Health Center

   ☐ Healthcare for the Homeless ☐ Public Housing ☐ FQHC Look-Alike

2. **When did you receive designation as an FQHC or FQHC-LA?**

   _____

3. **How many patients do you serve annually? _____**

4. What <u>ON SITE</u> services does your organization provide (check all that apply)?

☐ Family Practice
☐ Behavioral Health
☐ In-house Pharmacy
☐ Chiropractic
☐ Internal Medicine
☐ Pediatrics
☐ Vision
☐ Other
☐ Dentistry
☐ OB/GYN (Women's Health)
☐ Podiatry

5. What are your hours of operation?

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____
Saturday _____
Sunday _____

If you have more than one site please provide the site name, address, hours of operation and ON-SITE services provided.

6. **Payer Mix:**

Medicaid _____%

Medicare _____%

Uninsured _____%

Third Party _____%

Other _____%

100%

7. **What counties/area are/will you be serving?**
If possible, please provide a map of your geographical service area.

8. **What primary care services are currently available in your area (i.e. other Safety Net Providers, Community Health Centers, Free Clinics, etc.)?**

9. **Briefly describe your organization's 1 – 3 year plan:**

Health Center Provider Profile

Please provide staffing information for the health center grantee only.

Provider Type	# Full Time Equivalent (FTE)	# Employees	PA/NP/CNM
Family Practice			
OB/GYN			
Pediatrics			
Internal Medicine			
Dental			
Behavioral Health			
Other			

10. What areas of technical assistance do you believe you will need from the association and its' members?

11. Which Committee of the Board of Director's might you be interested in volunteering for?

☐ Policy ☐ Workforce ☐ Membership ☐ Clinical Quality

12. What type of Electronic Medical Record (and version) is your organization using?

_____

13. Are you currently recognized as a Patient Centered Medical Home (PCMH)?

☐ Yes ☐ No

If yes, by which organization? If no, what is your timeline to become a PCMH?

_____

If you are unsure what a PCMH is, please check the box. ☐

Financial Information

14. What is your organization's tax status?

☐ For Profit ☐ Non-Profit

15. Which of the following grants do you receive (select all that apply)?

☐ City/Local ☐ County ☐ State ☐ Federal

16. What percentage of funding comes from the following sources?

Donations _____%

Fee for Services _____%

Foundations _____%

Fundraising _____%

Hospitals _____%

Other _____%

100%

17. What is your total annual health center operating budget? $_____

Description of Organization

Use this space to describe the history of your organization to date including information about the community or attach relevant documents with application.

Key Operational/Financial Staff Members

CEO/Executive Director: _____

Email: _____

Phone: _____

COO: _____

Email: _____

CFO/Finance Director: _____

Email: _____

HR Director: _____

Email: _____

Marketing/PR Director: _____

Email: _____

Key Clinical Staff Members

Medical Director: _____

Email: _____

Quality Improvement Director: _____

Email: _____

Dental Director: _____

Email: _____

Other Key Staff Members

Name: _____

Title: _____ Email: _____

Name: _____

Title: _____ Email: _____

Name: _____

Title: _____ Email: _____

Name: _____

Title: _____ Email: _____

As a condition of membership, employee contact information will be published in our membership directory and on the OACHC website.

OACHC
Ohio Association of Community Health Centers

Please note: *We believe this application is comprehensive, but a representative of OACHC or the Committee may contact you for more information. Please indicate who we should contact:*

Name: _____ *Title:* _____

Phone: (_____) _____ *Email:* _____

Thank you