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

Teresa Rios-Bishop
(614) 884-3101
tbishop@ohiochc.org

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

4. What **ON SITE** services does your organization provide (check all that apply)?

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

5. What are your hours of operation?

- Monday ________________________  Friday ________________________
- Tuesday ________________________  Saturday ________________________
- Wednesday ________________________  Sunday ________________________
- Thursday ________________________

*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.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th># Full Time Equivalent (FTE)</th>
<th># Employees</th>
<th>PA/NP/CNM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>OB/GYN</td>
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<tr>
<td>Pediatrics</td>
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<td>Internal Medicine</td>
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<td>Behavioral Health</td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: _______________________________________
Organizational Membership Application

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.

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