



# Membership Application

## **Section 1. Definition of a Free Clinic**

According to the Ohio Revised Code, a Free Clinic is a nonprofit organization exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or a program component of a nonprofit organization, whose primary mission is to provide health care services for free or for a minimal administrative fee to individuals with limited resources.

A free clinic facilitates the delivery of health care services through the use of volunteer health care professionals and voluntary care networks. For this purpose, a free clinic shall comply with all of the following:

- a) If a free clinic does request a minimal administrative fee, a free clinic shall not deny an individual access to its health care services based on an individual's ability to pay the fee.
- b) A free clinic shall not bill a patient for health care services rendered.
- c) Free clinics shall not perform operations, as defined by divisions (A)(9) and (F)(1)(b) of section 2305.234 of the Ohio Revised Code.

A clinic is not a free clinic if the clinic bills Medicaid, Medicare, or other third party payers for health care services rendered at the clinic, and receives 25% or more of the clinic's annual revenue from the third-party payments.

In addition, the Ohio Association of Free Clinics recommends the following:

- A free clinic is committed to minimizing barriers to care and is involved in community-based efforts with this objective.
- A free clinic is committed to providing quality care and implements internal controls and procedures to meet this objective.
- A free clinic has a varied base of community support that should include, but not be limited to, individuals, businesses, churches, foundations, and government.
- If a free clinic is a program component of a nonprofit organization, the free clinic is overseen by an advisory board that focuses on the clinic exclusively.

**Section II. Organization Information**

Full Legal Name of Organization: \_\_\_\_\_

Trade Name (if different): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_, Ohio Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail Address:  
\_\_\_\_\_

Board President/Chair: \_\_\_\_\_

Executive Director: \_\_\_\_\_

Is this the organization named above a program component of another organization?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is the name of the other organization? \_\_\_\_\_  
\_\_\_\_\_

**Section III. Descriptive Information**

**Please attach the following documentation in the order in which it appears:**

1. I.R.S. 601(c)(3) Letter of Determination OR Application for 501(c)(3) Exemption OR I.R.S. Form 5548 Acknowledgement of Your Request for exemption.
2. Board roster (either Board of Trustees or Advisory Board) with names, addresses, phone numbers, employers and/or community affiliations (also identify officers and their titles)
3. Operating Budget
4. Most Recent Financial Statement
5. Clinic Brochure and/or Newsletter (if available)

**Please also respond to the following questions:**

1. What is the mission of the free clinic?
2. If the free clinic is a program of another nonprofit organization, is there an advisory board that directs the work of the free clinic? \_\_\_\_\_
3. What population(s) does the free clinic target? (Please include information such as geographic service area, demographics, etc.)
4. What are the criteria that are used to qualify patients?
5. How many paid Full Time Employees are employed by the clinic? \_\_\_\_\_
6. How many licensed medical professional and non-medical/lay volunteers are committed to the clinic? \_\_\_\_\_
7. How many volunteer hours are contributed annually? \_\_\_\_\_
8. Please describe what, if any, monies are collected from patients, including the type (i.e. suggested donation, fee, etc.), the amount, and the type of services for which fees are collected. Does the free clinic bill patients or deny care if the fee cannot be paid? Please describe the steps taken to make sure that the fees are not a barrier to care.
9. If the clinic bills their party payers, indicate the percentage of the annual operating revenues that comes from this source. \_\_\_\_\_
10. Are surgical procedures performed at the free clinics? \_\_\_\_\_
11. Does the free clinic hold a pharmacy license? \_\_\_\_\_

**Section IV. Signature and Remittance of Application Fee:**

By my signature below, I attest that all of the information contained in this application and the accompanying documents is true to the best of my knowledge and has been reviewed and approved by our Board of Directors. I furthermore attest that our organization, if accepted into the membership of the Ohio Association of Free Clinics, will comply to the best of our ability with all the terms and conditions of membership as set forth by the Association.

Our nonrefundable check of \$100.00 (made payable to the Ohio Association of Free Clinics) for the membership application fee is attached. This payment applies to membership for the first calendar year (January 1 - December 31). I understand that subsequent dues are based on budget size and will be billed annually.

A Free Clinic will remain current in the payment of annual membership dues and the reporting of uniform data required by the Association. It will be required to submit to the Association an annual application for membership renewal, the annual statistical survey, an annual budget, independent audit report and / or federal tax form 990.

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Signature of Executive Director or Board President

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Date

If you have any questions regarding this application, please contact Deb Miller, Director, at (614) 914 – 6458 or [deb@ohiofreeclinics.org](mailto:deb@ohiofreeclinics.org)

Please send completed applications to:  
Deborah Miller, Director  
Ohio Association of Free Clinics  
35 North Fourth Street; Suite 350  
Columbus, OH 43215