Charitable Healthcare Network
Full Membership Application

Full Membership Requirements

Organizations wishing to become a Full Voting Member must meet the following criteria:

- Is a 501(c)(3) tax-exempt organization or is part of a larger 501(c)(3)
- Is committed to providing quality care and implements internal controls and procedures to meet this objective
- Is committed to minimizing barriers to care and is involved in community-based efforts with this objective
- Does not deny an individual access to health care services based on an individual's ability to pay any fee

Your Organization Information

Full legal name of the organization:			
Month and year operations began:			
Organization type (i.e. free clinic, hybrid clinic, charitable pharmacy, charitable dental clinic, etc)	☐ Free Clinic ☐ Charitable Clinic ☐ Hybrid Clinic	☐ Charitable Pharmacy ☐ Charitable Dental Clinic ☐ Charitable Vision Clinic	
Senior staff name and title: (Primary Contact)			
Address (Used for patients seeking services):			
	Address		
	City	State	ZIP Code

Mailing address (if different):			
	Address		
	City	State	ZIP Code
Satellite site(s) name and address:			
Location #1			
Location #2			

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Location #3	
Counties served by your organization:	
Telephone:	
Fax:	
Email:	
Website:	
Federal Tax ID#	
Hours of operation (days and times	
Services Provided (select all that apply)	Medical Case Management Behavioral Health Lab and/or Diagnostic Services Pharmacy Social Services Other

Please describe what, if any, monies are collected from patients, including the type (i.e. suggested donations, fees, etc.) the amount, and the type of services for which fees are collected.

Does your organization 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.

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If your organization bills third party payers, indicate the percentage of the annual revenues that come from this source.

What is your mission statement?

What target population(s) does your organization target?

What are the criteria used to qualify patients?

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If more than one staff person/volunteer should be included in mailings, please include a separate list, including full name, email and mailing address for each individual. Clinic Board Members and Medical Directors are eligible and encouraged to receive information from CHN.

Signature

Title

Date Application Completed

Documents to include with application

Please attach the following documentation when submitting your application:

1. I.R.S. 501(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 Directors 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, Newsletter or other promotional materials.

There is a non-refundable application fee of $100.00. Checks can be made payable to "Ohio Association of Free Clinics".