



2012 Membership Application

Qualifications for Membership

1. Have an independent governing body composed of broad representation from the community
2. Are a tax exempt organization as follows:
 - Have 501 (c) (3) tax-exempt recognition from the Federal Internal Revenue Service or
 - Have applied for such status or
 - Are a program component of a larger 501 (c) (3) organization that provides other services
3. Are committed to providing quality healthcare services or healthcare related support services to the underserved while minimizing barriers to such care
4. Utilize volunteers and have a varied base of community support that includes individuals, business, churches, foundations and government

Please Check a Category

Clinic Membership Type	Please Enclose
<p>_____ NEW CLINIC MEMBERSHIP</p> <p>_____ Standard Level - \$50</p> <p>_____ Sustaining Level 1 - \$100</p> <p>_____ Sustaining Level 2 - \$250</p>	<p>_____ Membership Application</p> <p>_____ Payment</p> <p>_____ Copy of your 501 (c) (3) IRS determination letter</p> <p>_____ A copy of your Bylaws</p>
<p>_____ RENEWING CLINIC MEMBERSHIP</p> <p>_____ Standard Level - \$50</p> <p>_____ Sustaining Level 1 - \$100</p> <p>_____ Sustaining Level 2 - \$250</p>	<p>_____ Membership Application</p> <p>_____ Payment</p>

Name of Organization: _____

Year Opened: _____ Counties Served: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ Website: _____

Executive Director (ED): _____ Phone# of ED: _____

Email of ED: _____

Name/Title of Contact Person if other than ED: _____

Email of Contact Person: _____ Phone# of Contact Person: _____

Make checks payable to LSACC and send with this form to:
LSACC, PO BOX 684127 Austin, TX 78768-4127
 (For questions or additional information, please contact us at 512-777-8929)

PLEASE COMPLETE THE BACK OF THIS FORM

LSACC Use Only: Date Received: _____ Amount: _____ Check #: _____ Receipt Sent: _____

COMPLETE FOR CALENDAR YEAR 2011

PROGRAM SERVICES – CHECK ALL THAT APPLY

- Acute Medical Chronic Medical Dental Mental Health Health Education Immunizations
- Pharmacy
 - Licensed Pharmacy, Class _____
 - Samples PAP Programs \$4 RX's from local pharmacies
- Laboratory Services Imaging Services Specialty Care
 - On-Site Off-Site On-Site Off-Site On-Site Off-Site
- Other services please list: _____

STATISTICS AND FINANCIALS

Total Annual Cash Budget: \$ _____ Total Annual In-Kind Budget: \$ _____

Unduplicated Patients: Include each new patient and each returning patient, counting each only once per year.

Patient Visits: If the patient simply attended the clinic and received healthcare services

TOTAL UNDUPLICATED PATIENTS: _____ TOTAL PATIENT VISITS: _____

If you calculate the value of the services your clinic provides, please provide this total \$ _____

PAID STAFF

(If applicable, list the total **hours per week** that that you pay the following providers)

Dentist _____	Pharmacist _____
Physician _____	Mental Health _____
Nurse Practitioner _____	Nurse _____
Physician Assistant _____	Dental Hygienist/Asst _____

Excluding the providers above, how many total **hours per week** do you pay other healthcare professionals? _____

How many total **hours per week** do you pay **non-healthcare professionals?** _____

HEALTHCARE VOLUNTEERS AND HOURS

(Please list the total **yearly** number of volunteers in each category.)

Medical Providers (MD, DO, NP, PA.) _____	Other Healthcare Professionals _____
Dental Providers (DDS, RDH, Dental Assistant) _____	Total Number of Healthcare Volunteers _____
Pharmacy Providers (RPh, Pharmacy Technician) _____	Total Number of Healthcare Volunteer Hours _____
Mental Health Providers (Psychiatrist, LCSW, LPC) _____	Value of Service for Healthcare Volunteers \$ _____
Nurses (RN, LPN, MA) _____	

NON-HEALTHCARE VOLUNTEERS AND HOURS

Total **Yearly** Number of Non-Healthcare Volunteers _____ Total **Yearly** Number Non-Healthcare Volunteer Hours _____

Value of Service (**yearly**) Non-Healthcare Volunteers \$ _____

OTHER

- List how many hours per **week** you provide patient services Daytime _____ Evening _____ Weekend _____
- How many hours a **week** are you open for administrative tasks? _____
- Do you use an electronic health record system? If yes, please list which system. _____
- Average **yearly** patients turned away _____
- Average wait-time for new patients (if applicable) _____
- Fee For Service - Circle All That Apply Free Donation Sliding Scale Flat Fee Scale Medicaid/Chip