



ACTIVE MEMBER APPLICATION

Section I. Organization Information

Organization Name: _____

Street Address: _____

City: _____ Zip Code: _____

Mailing Address (if different):

City: _____ Zip Code: _____

Phone: _____ Fax: _____

E-Mail Address (office): _____

Web Site: _____

Executive Director/CEO/Clinic Manager _____

E-Mail Address: _____

Board President/Chair: _____

E-Mail Address: _____

Is the clinic a program component of a parent organization? Circle one: Yes No

If yes, indicate name of program: _____

If address is different than that of the organization address above, please provide program address:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Month and year the clinic began providing services: _____

Section II. Descriptive Information

Each numbered item represents one section your application for membership. Please attach the required documentation.

- 1. Private, nonprofit corporation that has a 501(c)(3) tax-exempt status, or has applied for 501(c)(3) tax-exempt status, or is a program component of a larger 501(c)(3) tax-exempt organization**

Required documentation:

- ___ Articles of Incorporation
- ___ I.R.S. 501(c) (3) Letter of Determination *OR* I.R.S. Form 5548 “Acknowledgement of Your Request” for Exemption
- ___ A copy of clinic’s Board-approved annual budget

2. Independent governing board (Board of Directors) composed of broad representation from the community, or an advisory board, if the program is a component of a larger organization.

Required documentation:

- ___ Board roster with names and/or community affiliations (identify officers and their titles)
- ___ Advisory Board list, if applicable

3. Primary mission is to provide health care services to individuals with limited resources (i.e. low-income, uninsured)

Required documentation:

- ___ Mission statement
- ___ The names of the counties and/or cities comprising your service area
- ___ A copy of the clinic’s patient eligibility requirements

4. Health care services include one or more of the following: medical care, dental care, mental health counseling, and pharmacy. As part of the delivery of this care, the program goal should be to provide the following services: general care, care coordination, access to specialty care, access to labs and diagnostic procedures, and access to prescription medications.

Required documentation:

___ What health care service does your organization offer? (please check all that apply)

- ___ Medical Care
- ___ Dental Care
- ___ Mental Health Counseling
- ___ Medications
- ___ Other _____

___ Number of unduplicated patients served in the past 12 months _____

5. Utilize volunteer health professionals that provide a significant portion of the health care services.

Required documentation

___ Description of relationship of volunteer and paid staff in the delivery of services, by position type

6. Varied base of community support that includes, but is not limited to, individuals, businesses, hospitals, churches, and foundations

Required documentation:

___ *Briefly* describe fund raising activities in the past twelve months, including grants, events, individuals, corporations, churches, hospitals etc. *OR* submit the organization’s annual report

Section III. 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.

Signature

Title

Date

Mail application, supporting documentation and dues check to:

Georgia Free Clinic Network

PO Box 133224

Atlanta, GA 30333

Membership in GFCN does not guarantee eligibility for funding opportunities sponsored by the association. Each funding opportunity may have its own eligibility criteria.