FREE CLINIC ASSOCIATION OF PENNSYLVANIA (FCAP)

Membership Application – FY 19-20

Legal Name of Organization: _____

Trade Name (if different):_____

Mailing Address: _____

City: _____ State _____ Zip Code: _____

Phone: _____ Fax: _____ Web Address: _____

Exec. Director/Primary Contact Person: _____

Phone: _____ Email Address: _____

If your organization is a program component of another organization, what is the name of the other organization?

_____

Does your clinic have any satellite sites? _____ If yes, please provide the address(es):

_____

_____

Clinic service area (counties and/or cities): _____

# of paid staff: _____ full time ____ part time # volunteers: _____medical ____ non-medical

Total volunteer hours last year: _____ Total medical volunteer hours: ___ Total non-medical hours last year _____

Does your clinic have a formal collaboration with your local hospital? _____ Yes _____ No

Does your organization charge any fees to patients? Yes _____ No _____

Do you bill any third party payors? ____Yes _____ No. If yes, who do you bill?

PATIENTS AND POPULATIONS SERVED IN YOUR LAST FISCAL YEAR

Service Provided	Unduplicated Patients Served	Total Patient Visits
Medical Program		
Dental Program		
Case Management/Social Services		
Pharmacy		
Behavioral Health		
_____Total		

Do you participate in the Federal Tort Claims Act (FTCA) for malpractice coverage? _____ Yes _____No

Check the appropriate size of your operating budget and submit a non-refundable check for the membership dues made payable to: FCAP or *Free Clinic Association of Pennsylvania.*

____ Budget of up to $100,000 - $100 per year
____ Budget of $100,001-150,000 - $200 per year
____ Budget of $150,001-$500,000 - $350 per year
____ Budget of $500,001-$750,000 - $500 per year
____ Budget $750,001 and above - $1,000 per year

Federal EIN #_____

Current Operating Budget _____

Fiscal Year _____ to _____
Month Month

By my signature below, I certify that the information provided in this application, including all statements and documentation, is true and correct and that I am authorized to submit this application on behalf of the organization. I furthermore attest that our organization, if accepted into the membership of the Free Clinic Association of PA, will comply to the best of our ability with all the terms and conditions of membership as set forth by the Association.

I understand that the membership dues, as outlined above, cover our application and, if the application is approved, cover dues for July 1, 2017 through June 30, 2018. I also understand that the FCAP Board of Directors may change this dues structure at any time.

_____ _____

Signature of Executive Director or Board President Date

MAIL COMPLETED APPLICATION TO:

Cheryl White, Treasurer
Free Clinic Association of PA
2520 Green Tech Drive, Suite D
State College, PA 16803

Questions? Email executivedirector@freeclinicspa.org