Membership Application

NAME AND CONTACT INFORMATION

Clinic Name: _____

Parent Organization (if applicable): _____

Physical Address: _____ City: _____ State: ___ Zip: _____

Mailing Address: _____City: _____ State: ___ Zip: _____

Main Phone: _____ Admin. Phone: _____

Website/URL: _____ Federal EIN: _____

Primary Contact: _____ Primary Email: _____

Additional Contact: _____ Additional Email: _____

MAFCC Membership Criteria

Please initial next to each statement that indicates whether your clinic/program qualifies to be a member of MAFCC:

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_____ *Our clinic/program is a (check one):*

- ❑ free clinic (charges no fees)
- ❑ charitable clinic (charges some fees)
- ❑ hybrid clinic (free or fee-based clinic that bills Medicaid)

_____ *Our clinic/program is a (check one):*

- ❑ 501(c)(3) organization or similar organization defined in state statute
- ❑ program component of a 501(c)(3) organization.
- ❑ statutorily defined social welfare board

_____ *Our clinic/program provides (check all that apply):*

- ❑ medical care
- ❑ dental care
- ❑ eye care
- ❑ behavioral health care

❑ pharmacy and/or medication assistance services

_____ Our clinic/program serves primarily low-income, uninsured and/or underserved populations.

_____ Our clinic/program is a (check all that apply):

❑ free-standing ("bricks and mortar") clinic

❑ referral network ("clinic without walls")

❑ mobile health clinic ("clinic on wheels")

❑ portable health program ("pop-up clinic")

_____ Our clinic/program is not a crisis pregnancy center only, a health screening program only, a health education program only, or a wellness program only.

_____ Our clinic/program is not a federally qualified health center (FQHC), an FHQC look-alike, or a certified rural health clinic.

_____ Our clinic/program is open and operates at least once a month. The month and year our clinic/program opened was _____.

MAFCC Membership Commitment

Please initial next to each statement that indicates your commitment to become and remain a member of MAFCC in good standing:

Initial Here

_____ Our clinic/program commits to paying annual membership dues at the time of application and by March 1st of subsequent years.

_____ Our clinic/program commits to informing MAFCC immediately if we make any changes that may impact our membership eligibility (e.g. suspension of operations; ceases to be a free clinic or charitable clinic, etc.).

_____ Our clinic/program commits to attending at least 33% of the educational and networking meetings that MAFCC holds each year. Audio and/or video conferencing is permitted to meet this commitment.

_____ Our clinic/program commits to having a representative present at the MAFCC annual membership meeting each year (to be held during one of the educational and networking meetings noted above).

_____ Our clinic/program commits to responding to periodic email requests for information from MAFCC in a timely manner. As part of this, we commit to informing MAFCC promptly when our primary contact information changes.

Initial Here

_____ Our clinic/program commits to providing MAFCC with basic annual statistical information (e.g. # patients served, # visits provided, total operating expenses, etc.) each year, with the understanding that data will be compiled, aggregated, and summarized, and that no clinic's individual data will be reported or released by the MAFCC official designated to handle the data.

MAFCC Annual Dues

Please make a check payable to MAFCC for the amount of annual dues owed based on your annual operating expenses according to the table below:

Annual Operating Expenses* For Most Recent Fiscal Year	Annual Dues
<$100,000	$50
$100,000 - $250,000	$100
$250,000 - $1,000,000	$200
>$1,000,000	$300

* Include administration, fundraising, and program services expenses. Do not include in-kind contributions or capital expenditures.

By my signature below, I attest that I am an authorized representative of the applicant organization and that all information provided herein is true and correct to the best of my knowledge:

Printed Name of Authorized Representative: _____

Signature of Authorized Representative: _____

Date: _____

Please mail this form to MAFCC along with
a copy of your organization's 501(c)(3) letter of determination
(or articles of incorporation, if statutorily defined as a social welfare board)
and
check for your annual dues made payable to MAFCC.

MAFCC
c/o Social Welfare Board
904 South 10th Street, Suite A
St. Joseph, MO 64503

Questions? Contact Linda Judah at lindajudah@socialwelfareboard.org or (816) 344-5201