



MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

Serving Maryland and Delaware

ORGANIZATIONAL MEMBERSHIP APPLICATION

ORGANIZATION NAME (as you would prefer it to appear on brochures or publications, etc.):

WEB ADDRESS: _____

ADDRESS: _____

PHONE: _____ FAX: _____ E-MAIL _____

EXECUTIVE DIRECTOR: _____ EXTENSION: _____

MEDICAL DIRECTOR: _____ EXTENSION: _____

CHIEF FINANCE OFFICER: _____ EXTENSION: _____

ADMINISTRATIVE ASSISTANT: _____ EXTENSION: _____

DOCUMENTATION CHECKLIST (Please submit the following with your application):

- List of Services Provided
- Copy of Sliding Fee/Reduced Fee Scale and Sliding/Reduced Fee Policy
- Copy of BCRR/UDS, Annual Report or Data Sheets stating the percent or number of uninsured and Medicaid populations served for the most recent calendar year.
- Board of Directors list
- Mission Statement
- Current Audited Financial Statement
- Cost Report
- Annual Report
- Marketing Materials

I hereby certify that: (1) we support the mission of the Mid-Atlantic Association of Community Health Centers; (2) we meet the requirements for the membership category for which we have applied and have supplied all of the required documentation; and (3) all of the information provided on this application is accurate to the best of my knowledge.

Date

Signature (Executive Director or Board Chair)