georgia charitable care network

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)

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

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? (check all that apply)
   - ___ Medical Care
   - ___ Dental Care
   - ___ Mental Health Counseling
   - ___ Medications
   - ___ Other _____

   ____ Number of unduplicated patients served in the past 12 months_____

Section III. Signature and Remittance of 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 Charitable Care Network Inc.
PO Box 133224
Atlanta, GA 30333

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