Community Health Association
Inland Southern Region

Membership Application

621 E. Carnegie Drive, Suite 180
San Bernardino, CA 92408
(909) 566-2555

Regular Membership- Regular members serve as voting members on CHAISR Board of Directors. Please complete the information below.

What type of organization are you (check all that apply):

□ Behavioral Health Clinic	□ FQHC Look-Alike	□ Hospital-Based Clinic
□ Dental Clinic	□ Free Clinic	□ Mobile Clinic (exclusively)
□ Faith-Based Clinic	□ Free Standing, Non-Profit Corporation	□ Public/Government Clinic
□ FQHC		□ School-Based Clinic
□ Other (please specify):		

Regular Membership Annual Dues:

To determine the membership annual dues, the member organization will need to reference their total operating expenses for all clinics (according to their most current Office of Statewide Health Planning and Development Report or Board of Directors Approved Annual Budget) for all health clinics in the organization. If the member organization is a current/active member and in good standing of another Regional Association of California the dues may be based on their health centers/clinics located in San Bernardino and Riverside Counties. Exceptions to this limitation may be made by the Board of Directors.

If your total operating expenses for <u>all</u> clinics are *less* than $1,000,000 per year	$1000
If your total operating expenses for <u>all</u> clinics are *more* than $1,000,000 per year	0.15% x your total operating expenses

For the 2018 fiscal year, the maximum annual dues are <u>$10,000</u>.

Examples on how to calculate your membership dues:

- If your total operating expenses (TOE) are $509,774, then your annual dues are <u>$1000</u>.
- If your TOE are $2,457,943, then your annual dues are 0.0015 x $2,457,943, or $3,686.92.
- If your TOE are $20,413,333, then your annual dues are 0.0015 x $20,413,333, or $30,620.00. Your memberships dues are <u>$10,000</u> (based on the 2019 maximum).

Chief Executive Initial's _____

Regular membership is open to organizations that meet the following criteria:

1. The organization is licensed by the State of California, Department of Health Services, pursuant to Sections 1204 (a)(1) or (2) of the California Health and Safety Code, relating to "Community Clinics" or "Free Clinics," or is exempt from clinic licensure as an organization described in Section 1206 (b)(c) and (d) of the California Health and Safety Code.
2. The organization has a written policy of non-discrimination based on ability to pay.
3. The organization provides comprehensive primary health care to un-served and under-served populations in the Inland Southern Region.
4. The organization operates in a manner that furthers the mission of the Community Health Association Inland Southern Region.

***Please note, dues cover a calendar year, January 1 through December 31. If your application is approved after the beginning of a new membership year, your dues will be prorated through the end of December from the date of Board approval.**

Name of Organization (for individual or student affiliate status, please list your name)

Physical Address of Organization (if individual, your mailing address)

Mailing Address of Organization

Name of Chief Executive | Title

Direct Office Phone Number | Cell Phone Number

Email Address

Name of Secondary Contact or Delegate

Email Address of Secondary Contact or Delegate

Organization's Website Address

Federal Tax ID (EIN)

Chief Executive Initial's _____

Please submit the following items along with the application (if applicable):

1. Your organization's mission statement and vision statement.
2. A brief history of your organization and its Clinic/Community Health Center(s). Please include the name and address of **all** clinic/health center sites in San Bernardino and Riverside Counties (or in adjacent county serving residents living in San Bernardino and Riverside Counties).
3. Describe the specific geographic catchment areas for your San Bernardino and Riverside County locations (Zip codes and cities served).
4. The specific health care needs in your catchment area(s) and how your clinic(s) meet those needs for the residents.
5. List, a) the number of unduplicated patients you serve annually by health center/clinic site, and 2) the total number of annual visits by site.
6. Lastly, please share why you are applying for membership.

Additional Information to Submit (if applicable):

1. Copy of IRS 501(c)(3) Determination Letter.
2. Copies of current California Department of Public Health licenses for each clinic site.
3. Copy of the non-discrimination based on the ability to pay policy.
4. Copy of your current fee schedule.
5. Current list of Board of Directors and Officers.
6. Letter of Recommendation for membership from a CHAISR regular member in good standing.
7. Financial document, latest OSHPD expense report or Board Approved budget for each clinic site, to support the calculated membership dues listed below.

Please submit your complete application to Dr. Deanna Stover, CEO:

- **Email at dstover@chaisr.org, and**
- **Mail an original to the CHAISR office at:**
  621 E. Carnegie Drive, Suite 180
  San Bernardino, CA 92408

The CHAISR Board of Directors reviews all membership applications. The final decision to grant membership will be at the discretion of the Board of Directors. If approved, all new members and affiliates will be invoiced for the annual dues, prorated based on the date of Board approval.

We appreciate your interest in becoming a member of CHAISR and thank you for supporting our goal of meeting the health needs of our communities!

Chief Executive Initial's _____

Please calculate your membership dues:

Your organization's current fiscal year total operating expenses: $_____

Your organization's annual calculated membership dues (refer to page 2): $_____

By signing below, I attest that the information contained in the membership application is accurate to the best of my knowledge, and that I have the authority to apply for membership and approve membership dues payment for the organization I am representing.

Chief Executive Signature	**Printed Name**	**Date**

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