2021 IAFCC Membership Application

Thank you for joining us for another year! Please complete the following application, upload all supporting documentation, and send your payment.

If you prefer to complete this on paper, please visit our website at https://www.illinoisfreeclinics.org/for-members/iafcc-membership-application to download. Please send your completed application together with all supporting documentation to:

Illinois Association of Free & Charitable Clinics
42 Stephen Street #416
Lemont Il, 60439

If you have any problems or questions, please contact Melissa Maguire (executivedirector@illinoisfreeclinics.org). We look forward to another amazing year together!

Any files that are uploaded will be shared outside of the organization they belong to.

* Required

1. Email address *

Clinic Information

2. Clinic Name: *

3. Mailing Address *

4. City *

5. State *

6. Zip Code *

7. Phone *

8. E-mail Address *

9. If your clinic is a program component of another organization, what is the name of the other organization? *

10. Does your clinic have any satellite sites? If yes, please provide the addresses *

11. Website (URL): *

12. Tax Exempt Status 501(c)3: *

Mark only one oval.

- Yes
- No

13. What counties does your clinic serve? *

14. If you wrote Cook County, write in the neighborhoods, community areas, or suburbs that you serve.

15. Does your organization charge patients for any services? *

Mark only one oval.

- ◯ Yes, and fee is required (denies service if patient cannot pay)
- ◯ Yes, but fee is not required (sees all patients regardless of ability to pay)
- ◯ No, but we accept donations
- ◯ No, we do not accept payment of any kind

16. Do you bill for third party reimbursement? *

Mark only one oval.

- ◯ Yes *Skip to question 17*
- ◯ No *Skip to question 18*

Which of the following do you bill for reimbursement?

17. Please check all that apply: *

Check all that apply.

- ☐ Medicaid
- ☐ Medicare
- ☐ Private Insurance
- ☐ Dental Insurance
- Other: ☐ _____

Do you intend to start billing for third-party reimbursements in the next year?

18. *

Mark only one oval.

- Yes
- No

Clinic Information: Financial

19. What was your cash-operating budget in the past year? Either fiscal or calendar year. Exclude capital, donated time, or goods/services. *

20. Which of the following best describes your sources of financial support in the past year? Please rate accordingly. *

Mark only one oval per row.

	Large Source of Support	Medium Source of Support	Small Source of Support	Not Currently a Source of Support
Patient Fees				
Medicare/Medicaid				
Patient Insurance				
Federal Government Grants				
State Government Grants				
Local Government Grants				
Individuals				
Corporations				
Civic Groups/Professional & Member Organizations (e.g. Rotary, medical society, etc.)				
Foundations				
Hospitals				
Medical School/University				
Health Professions Training Programs				
Religious Organizations/Faith Community				

Special Events (Fundraisers, etc)				

Your Patients: Target Populations

21. As free and charitable clinics, we understand that it is your goal to treat those in need. That being said, does your clinic specifically seek to address the health needs of any of the following groups (i.e. target populations)? *

Check all that apply

Check all that apply.

- [ ] Homeless
- [ ] Immigrants
- [ ] Uninsured
- [ ] Underinsured
- [ ] Children
- [ ] Adults
- [ ] Seniors (65+)
- [ ] Veterans
- [ ] LGBTQ
- [ ] Transgender and/or gender non-conforming
- [ ] HIV/AIDS
- [ ] Individuals with substance abuse disorders
- [ ] Formerly incarcerated
- [ ] Victims of intimate partner violence

Other: [ ] _____

22. What criteria does your organization use to determine if a patient is eligible to receive services? Check all that apply. *

Check all that apply

Check all that apply.

- [ ] Must be uninsured
- [ ] Must be a legal resident
- [ ] Must live in the same county that clinic is located
- [ ] Must be working or actively seeking work
- [ ] Must be ineligble for medicaid or other insurance coverage
- [ ] Must be less than a certain percentage of FPL

Other: [ ] _____

Your Patients: Gender

What percentage of male, female, Transgender Female-to-Male (FTM), Transgender Male-to-Female (MTF), and Gender non-conforming patients did you serve in the past year? Please provide best estimate of percentages in the fields below. Please make sure the percentages add up to 100%.

23. % Male Patients

_____

24. % Female Patients

_____

25. % Transgender FTM Patients

_____

26. % Transgender FTM Patients

_____

27. % Transgender MTF Patients

28. % Gender Non-Conforming Patients

Your Patients: Age

What percentage of your patients in the past year were children, adults or older/elderly adults? Please provide best estimate of percentages in the fields below. Please make sure percentages add up to 100%.

29. 0-17 years old:

30. 18-64 years old:

31. 65+ years old:

Your Patients: Race/Ethnicity

What race/ethnicity best describes your patients in the past year? Please provide best estimate of percentages for each of the following groups in the fields below. Please make sure the percentages add up to 100%.

32. Latino or Hispanic:

33. White:

34. Black or African-American:

35. Asian:

36. American Indian or Alaska Native:

37. Native Hawaiian or Pacific Islander:

38. Multi-racial or Bi-racial:

39. Other (Please specify)

40. Don't Know

Your Patients: Income Level

What percentage of patients seen in the past year fall into the following Federal Poverty Level (FPL) income brackets? Please provide your best estimate of percentages in the fields below. Please make sure percentages add up to 100%.

Federal Poverty Level Income Brackets

Number of Persons in Household	100% of Federal Poverty Level	200% of Federal Poverty Level
1	$12,880	$25,760
2	$17,420	$34,840
3	$21,960	$43,920
4	$26,500	$53,000
5	$31,040	$62,080
6	$35,580	$71,160
7	$40,120	$80,240
8	$44,660	$89,320

41. Below 100% of FPL:

42. Between 100% and 200% of FPL:

43. Over 200% of FPL:

Your Patients: Population Density

What percentage of patients seen in the past year live in urban, suburban or rural areas? Please provide best estimate of percentages. Please make sure percentages add up to 100%.

44. Urban:

45. Suburban:

46. Rural:

Your Patients: Medical Conditions

What are the five most common conditions treated at your clinic in the past year? Please provide best estimate of percentage of total patients in field following each condition for the five most common conditions treated at your clinic.

47. Diabetes

48. Hypertension

49. Asthma/COPD

50. Cancer

51. Obesity

52. Dental Care

53. Sexual Health

54. Dyslipidemia/Hypercholesterolemia

55. Vision Screenings and Exams

56. Arthritis

57. Mental Health

58. Physicals (school, sport, or general)

59. Acute Injury

60. Hearing Screening and Exam

61. COVID Testing

62. COVID Immunization

63. Other

64. What other conditions, if any, are challenging to address or are a high priority for your clinic?

65. What are the most important barriers to the management of your clinic's most common conditions?

Check all that apply.

- [ ] Medications
- [ ] Diagnostic Tests
- [ ] Specialists
- [ ] Procedures
- [ ] Funding Avenues
- [ ] Patient Lifestyle Modification
- [ ] Food Access
- [ ] Literacy
- [ ] Patient Education
- [ ] Patient Competing Priorities

Other: [ ] _____

66. How can the IAFCC help your clinic address these barriers?

_____

_____

_____

_____

_____

Skip to question 67

Clinic Services: Medication

67. How would you describe your on-site pharmaceutical facilities? *Note: a pharmacy distributes medications packaged from their own bulk supplies, while a dispensary distributes pre-packaged samples and medications. *

Mark only one oval.

- ◯ Licensed/certificate/permitted pharmacy
- ◯ Dispensary
- ◯ None

68. Does your clinic want to establish on-site pharmaceutical facilities?

Mark only one oval.

- ◯ Yes
- ◯ No

69. What are the major barriers preventing establishment of on-site pharmaceutical facilities?

Check all that apply

Check all that apply.

- ☐ Too expensive
- ☐ Lack of staff or volunteer time
- ☐ Lack of staff or volunteer expertise
- ☐ Lack of legal expertise
- ☐ Lack of site for pharmaceutical facility
- ☐ Other (please specify)

70. How could the IAFCC help your clinic address these barriers?

71. How do you arrange medications for your patients?

Check all that apply

Check all that apply.

- [ ] Physician prescription
- [ ] Physician samples
- [ ] Drug company patient assistance program
- [ ] Drug company bulk donation/replacement
- [ ] Charitable distributor donation (i.e. Americares)
- [ ] Charitable fill pharmacy on-site
- [ ] Charitable fill pharmacy off-site
- [ ] 340(b) drug program
- [ ] Stock bottles
- [ ] Pay outside pharmacy/pharmacy voucher
- [ ] Pay for specific (not stock or bulk) patient medications
- [ ] Generics through $4 Walmart plan

Other: [ ]

72. What was the total number of on-site prescriptions filled or medications dispensed in the past year? Please provide your best estimate.

Clinic Services

73. Which of the following best describes the services provided by your clinic(s)?

We recognize that your clinic(s) may have multiple resources to provide a given service. If applicable, please choose the option that best reflects your clinic's primary resource. "Refer Out" means that there is an agreement between your clinic and an external provider and that external provider will serve patients referred by your clinic.

Mark only one oval per row.

	On-Site	Refer Out	Not Available - Planning to add in next 12 months	Not Available - Would like to add but not currently planned	Not Available - Not a priority
Urgent/Acute Care					
Yearly physicals					
Immunization- Non COVID					
Immunization- COVID					
Laboratory					
X-ray (non-dental)					
Chronic Disease Management					
Dental Care					
Vision Screening					
Family Planning					
Prenatal/Obstetrical Care					
Gynecological					
STI Testing/Treatment					
HIV Testing					
TB Testing					
Substance Abuse Treatment/counseling					

Mental Health Treatment/counseling					
Specialty Services					
Eyeglasses					
Case Management					
Health Education					

Please provide an unduplicated number of patients who utilized the following service types:

74. Medical program

75. Dental program

76. Case Management/Social Services

77. Pharmaceutical

78. Mental health

*Mental health services provided by a psychiatrist, licensed psychologist, professional counselor, or clinic social worker. Do not count mental health treatment provided by primary health care providers

79. Other

80. Total number of patients annually *

Please provide a count of visits made last fiscal year for the following service types:

81. Medical Program

82. Dental program

83. Case Management/Social Services

84. Pharmaceutical

85. Mental health

*Mental health services provided by a psychiatrist, licensed psychologist, professional counselor, or clinic social worker. Do not count mental health treatment provided by primary health care providers

86. Other

87. Total patient visits

88. Does your clinic provide any other services that were not addressed above?

Telehealth

89. Is your clinic currently using Telehealth Services

Mark only one oval.

- Yes
- No

90. Choose the telehealth technology the clinic currently uses: (all that apply)

Check all that apply.

- [ ] Telephone Appointments
- [ ] Text Messages
- [ ] Video Appointments
- [ ] Other: _____

91. Is your clinic currently working with a telehealth vendor?

Mark only one oval.

- ◯ Yes
- ◯ No

92. If yes: which vendor is your clinic currently working with?

_____

Clinic Services: Referrals

93. Would you like to expand your referral capacity or affiliation with a hospital or external provider? *

Mark only one oval.

- ◯ Yes
- ◯ No *Skip to question 95*

94. Please list 3 referral services that would be most important to your patient population? *

Staff and Volunteers

95. How many full-time employees work at your clinic? *

96. How many part-time employees work at your clinic? *

97. How many volunteers do you have at your clinic? *

98. How many of your volunteers are providers? *

99. How many of your volunteers support in other capacities? (admin, reception, teach classes, etc.) *

100. On average, how many volunteer-hours are worked at your clinic per week? Please provide best estimate of hours. *

_____

101. Which of the following best describes your clinic's ability to recruit volunteers to meet your needs? *

Mark only one oval.

- ◯ Almost Always
- ◯ Often
- ◯ Sometimes
- ◯ Seldom
- ◯ Never

102. Do you provide clinical training to students? *

Check all that apply

Check all that apply.

- ☐ Yes, for medical students or residents
- ☐ Yes, for nursing students
- ☐ Yes, for dental students
- ☐ Yes, for psychology students
- ☐ Yes, for social work students
- ☐ Yes, for pre-health students
- ☐ No

Other: ☐ _____

Language Services

103. What percent of your patient population is not proficient in English? Please provide best estimate of percentage. *

_____

104. Besides English, which of the following languages are spoken by a significant number of your patients? *

Significant implies your clinic services are informed by these languages (interpreter services, translated materials). Check all that apply.

Check all that apply.

- [ ] Arabic
- [ ] Hindi
- [ ] Polish
- [ ] Spanish
- [ ] Gujarati
- [ ] Urdu
- [ ] Mandarin

Other: [ ] _____

105. Which of the following best describes the interpretation service provided by your clinic(s) for each language? *

We recognize that your clinic(s) may have multiple resources to provide language interpretation for your patients. If applicable, please choose the option that best reflects your clinic's primary service.

Mark only one oval per row.

	On-Site Medical Interpreter	Off-Site Video Medical Interpreter	Off-Site Telephonic Medical Interpreter	Staff Member (Non-Professional) Interpreter	None/Not Applicable
Arabic	◯	◯	◯	◯	◯
Gujarati	◯	◯	◯	◯	◯
Spanish	◯	◯	◯	◯	◯
Hindi	◯	◯	◯	◯	◯
Urdu	◯	◯	◯	◯	◯
Mandarin	◯	◯	◯	◯	◯
Other	◯	◯	◯	◯	◯

Quality Improvement

106. Does your clinic track and/or use data about the quality of care to make improvements (i.e. Quality Improvement)? *

Mark only one oval.

- ◯ Yes
- ◯ No

107. Which of the following data categories do you track? *

Check all that apply

Check all that apply.

- ☐ Demographics
- ☐ Outcomes
- ☐ Patient Feedback/Satisfaction
- Other: ☐ _____

108. What are the main challenges that your clinic faces in implementing QI strategies? *

Check all that apply

Check all that apply.

- ☐ Lack of Electronic Medical Record
- ☐ Lack of financial resources
- ☐ Lack of staff or volunteer time
- ☐ Lack of staff or volunteer knowledge
- ☐ Lack of expertise in QI methodology
- ☐ Lack of expertise in how to collect QI data
- ☐ Lack of expertise in how to interpret QI data
- ☐ Lack of clinic staff buy-in
- ☐ Not a priority at this time
- Other: ☐ _____

Electronic Medical Record

109. Does your clinic currently have an Electronic Medical Record (EMR) system installed and in use? *

Mark only one oval.

- ◯ Yes
- ◯ No

110. In what capacity are you using your EMR? *

Check all that apply

Check all that apply.

- ☐ Exchange records with hospitals and other care providers
- ☐ Track patient demographics
- ☐ Track conditions treated
- ☐ Track patient outcomes
- ☐ Scheduling
- ☐ Prescriptions
- ☐ We currently don't utilize an EMR

Other: ☐ _____

111. Would you like to acquire an Electronic Medical Record (EMR) system in the next 12 months? *

Mark only one oval.

- ◯ Yes
- ◯ No *Skip to question 113*

112. What are the major barriers to acquiring an Electronic Medical Record system? *

Check all that apply

Check all that apply.

- [ ] Too expensive
- [ ] Lack of expertise in setting up EMR
- [ ] Lack of expertise in operating EMR
- [ ] Lack of volunteer time to set up EMR
- [ ] Cannot transfer paper records to EMR
- [ ] Lack of clinic staff buy-in

Other: [ ] _____

Summary

113. Is there anything in this application that we didn't ask that you would like us to know about your clinic?

_____

_____

_____

_____

_____

114. What are three things you would like IAFCC to address and/or continue this year?

_____

_____

_____

_____

_____

Membership

For New Members:
o Current annual operating budget
o Current Board roster including community affiliations, your board officers and their titles.
o Mission Statement of the organization
o Program Brochure or recent information flyer (If applicable)
o FOR NEW MEMBERSHIPS ONLY - IRS 501(c)3 Letter of Determination or Application for 501(c)3
Exemption, or IRS Form 5548 “Acknowledgement of Your Request” for Exemption

Current Members:
o Current annual operating budget
o Please send if any changes to Board roster, mission statement, or program brochures

115. Current Annual Operating Budget

Files submitted:

116. Current Board roster including community affiliations, your Board Officers, and their titles

Files submitted:

117. Mission statement of the organization

Files submitted:

118. Program brochure or recent information flier (if applicable)

Files submitted:

119. IRS 501(c) Letter of Determination or application for 501(c)3 exemption, or IRS form 5548 "Acknowledge of Your Request" for exemption

Files submitted:

120. Check the appropriate size of your operation budget. Your membership dues are based on your clinic's annual operating budget.

Check all that apply.

- [ ] Budget of $0-$250,000--------$50 per year
- [ ] Budget of $250,001-$500,000--------$125 per year
- [ ] Budget of $500,001-$1,000,000--------$250 per year
- [ ] Budget of $1,000,001 or more--------$500 per year

Payment Types:

Non-refundable check:
If paying by check, complete this application form and upload all supporting documentation, at the same time. Please make your check payable to: Illinois Association of Free & Charitable Clinics and mail to:

Illinois Association of Free & Charitable Clinics
42 Stephen Street #416
Lemont Il, 60439

Pay by PayPal:
If paying through PayPal, PayPal payments can be made to info@illinoisfreeclinics.org. Please complete the application, and upload all supporting documents. PayPal links are provided in the payment options below.

121. Based on the budget criteria above, please select your payment type

Check all that apply.

- [ ] $50 check
- [ ] $125 check
- [ ] $250 check
- [ ] $500 check
- [ ] $50 Paypal. If selecting this option, proceed to https://goo.gl/rxpPsE
- [ ] $125 Paypal. If selecting this option, proceed to https://goo.gl/CrT8Lh
- [ ] $250 Paypal. If selecting this option, proceed to https://goo.gl/zFeMMG
- [ ] $500 Paypal. If selecting this option, proceed to https://goo.gl/Fdm1Ew

Submission

122. Thank you for taking the time to complete the IAFCC Membership Application. Are you ready to submit?

Mark only one oval.

- ◯ Yes