2022 Non Free & Charitable Clinic (FCC) VHCP Program Enrollment

Welcome to the 2022 Volunteer Healthcare Provider (VHCP) Program Application. Please complete this application if your organization would like to enroll in the VHCP Program. If you do not have data on certain questions, provide your best estimate.

* Required

1. Email *

2. Date *

Example: January 7, 2019

CONTACT INFORMATION

3. First Name *

4. Last Name *

5. Email *

6. Phone *

ORGANIZATION INFORMATION

7. My Organization is considered a: *

Mark only one oval.

- ◯ Free Clinic
- ◯ Charitable Clinic
- ◯ Hybrid Charitable Clinic
- ◯ Free-Charitable Pharmacy
- ◯ Other: _____

8. Organization Name *

_____

9. Organization Phone *

_____

10. Website URL *

_____

Organization Address

11. Street *

_____

12. City *

_____

13. State *

14. Zip Code *

TARGET POPULATIONS OF ORGANIZATION

Your Patients Gender (%)

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%.

15. % Male Patients *

16. % Female Patients *

17. %Undisclosed *

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 all the percentages add up to 100%. Round to the nearest whole number.

18. % 0-17 years old *

19. % 18-64 *

20. % 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 percentages add up to 100%.

21. % Latino or Hispanic *

22. % White or Caucasian *

23. % Black or African American *

24. % Asian or Hmong *

25. % American Indian or Alaska Native *

26. % Native Hawaiian or Pacific Islander *

27. % Multi-racial or Bi-racial *

28. % Other *

29. % Unknown *

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 into he 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

30. % Below 100% of FPL: *

31. % Between 100% and 200% of FPL: *

32. % Over 200% of FPL: *

Your Patient's Language

33. What percentage of your patient population does not speak English as their primary language? *

Please provide best estimate of percentage (list as percent number, example: 20% not 0.20).

34. Besides English, which of the following languages are spoken by your patients? Check all that apply. *

Check all that apply.

- [ ] Arabic
- [ ] Hindi
- [ ] Polish
- [ ] Spanish
- [ ] Gujarati
- [ ] Urdu
- [ ] Mandarin
- [ ] French
- [ ] Russian
- [ ] Punjabi
- [ ] Hmong
- [ ] Sudanese
- [ ] Somali
- [ ] Burmese
- [ ] Rohingya
- [ ] Tibetan
- [ ] ASL
- [ ] Only English

Other: [ ] _____

35. Does your organization provide interpretation services for your patients? If so, for which languages? *

Check all that apply.

- [ ] Spanish
- [ ] Arabic
- [ ] Hindi
- [ ] Polish
- [ ] Gujarati
- [ ] Urdu
- [ ] Mandarin
- [ ] French
- [ ] Russian
- [ ] Punjabi
- [ ] Hmong
- [ ] Sudanese
- [ ] Vietnamese
- [ ] Somali
- [ ] Burmese
- [ ] Rohingya
- [ ] Tibetan
- [ ] ASL

Other: [ ] _____

36. Which of the following best describes the services provided by your organization: *

We recognize that your organization 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					
COVID Testing					
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					

YOUR PATIENT VISITS AND TESTS

37. Total Number of all Medical VISITS (both primary care AND specialty visits for both new and established patients) *

*specialty visits include all specialties such as gyn, cardiology, endocrinology, etc. - DO NOT include mental/behavioral health or dental visits in this total *

38. Total Number of Established Patient On-Site Medical Visits (both primary care and specialty visits) *

39. Number of Telehealth Visits *

40. Number of Dental Visits *

*Note: this is different from number of dental PATIENTS. One patient could have more than one visit in a year

41. Number of Mental Health Visits *

42. Number of Pharmaceutical Visits *

43. Number of Case Management/Social Services *

44. Total Patient VISITS (roughly should be sum of dental, medical and mental health/behavioral visits) *

STAFF AND VOLUNTEERS

45. How many total (clinical/non-clinical) paid full-time employees work at your clinic? (Equal to or greater than 32 hours per week) *

46. How many total (clinical/non-clinical) paid part-time employees work at your clinic? (Less than 32 hours per week) *

47. How many total paid employed providers do you have? (MDs, DOs, PAs, NPs, DDSs, DMDs, RDHs) *

48. How many volunteers do you have at your organization? *

49. How many of your volunteers are providers? (MDs, DOs, PAs, NPs, DDSs, DMDs, RDHs) *

IMPORTANT! PLEASE READ BELOW.

To complete the enrollment process, you will receive an email with instructions for enrolling your providers after submitting this form. (The email will be sent within 1-2 weeks.)