2022 Free & Charitable Clinic (FCC) WAFCC Membership and/or VHCP Enrollment Form

* Required

1. Email *

Welcome to the consolidated Wisconsin Association of Free & Charitable Clinics (WAFCC) Membership Application and Volunteer Healthcare Provider (VHCP) Program Enrollment Form. Please submit this form if your organization is a free and charitable clinic and would like to be a member of WAFCC AND/OR VHCP. If you do not have data on certain questions, please provide your best estimate. If you have any questions about completing this form, please refer to the following FAQ document and/or contact Heather Ule at 440-781-3513: https://docs.google.com/document/d/13kTrY4skc0pGp3wgS2DbWT8THloWkDmn/edit?usp=sharing&ouid=107190136327167330557&rtpof=true&sd=true

2. IMPORTANT PLEASE CHOOSE ONE *

Mark only one oval.

- VHCP Enrollment and WAFCC Membership
- VHCP Enrollment (Only)
- WAFCC Membership (Only)

3. Date *

Example: January 7, 2019

CONTACT INFORMATION

4. First Name of Person Completing this Form *

5. Last Name of Person Completing this Form *

6. Email of Person Completing this Form *

7. Phone Number of Person Completing this Form *

8. Organization's Primary Contact Name *

9. Organization's Primary Contact Position/Title *

10. Organization's Primary Contact Email *

ORGANIZATION INFORMATION

11. My organization is considered a: *

Mark only one oval.

- Free Clinic
- Charitable Clinic
- Hybrid Charitable Clinic
- Free-Charitable Pharmacy

12. Organization Name *

____

13. Organization Phone *

____

14. Website URL *

____

Organization Address

15. Street *

____

16. City *

____

17. State *

18. Zip Code *

19. Does your organization have any satellite locations? If yes, list each satellite site, their locations, and phone number below.

20. Does your organization have mobile capabilities to extend your services in community? *

Mark only one oval.

- Yes
- No

21. If yes, explain.

22. Which counties are served by your organization? *

FINANCIAL DATA

23. Federal EIN (Tax ID) *

24. Tax Exempt Status 501(c)3 *

Mark only one oval.

- Yes
- No

25. What was your total cash-operating expenditure in the past year? Either your most recently completed fiscal or calendar year (by 12/31/21). Exclude capital spending as well as donated time, goods, and services. *

26. What is the approximate total revenue received from patient fees and reimbursements of services in the past year? *

27. Do you bill for third party reimbursement? *

Mark only one oval.

- Yes
- No

28. If yes, which of the following do you bill for reimbursement:

Check all that apply.

- [ ] Medicaid
- [ ] Medicare
- [ ] Private Insurance
- [ ] Dental Insurance
- [ ] Other

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

Mark only one oval.

- ( ) Yes, and fee is required
- ( ) Yes, but fee is not required
- ( ) No, but we accept donations
- ( ) No, we do not accept payment of any kind

TARGET POPULATIONS OF ORGANIZATION

30. 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
- [ ] Primary Language other than English
- [ ] Uninsured
- [ ] Underinsured
- [ ] Children
- [ ] Adults
- [ ] Seniors (65+)
- [ ] Veterans
- [ ] LGBTQ
- [ ] Transgender and/or gender non-conforming/non-binary
- [ ] HIV/AIDS
- [ ] Individuals with substance abuse disorders
- [ ] Individuals with history of psychiatric disorder
- [ ] Formerly incarcerated
- [ ] Victims of intimate partner violence16
- [ ] Other

Your Patients Gender (%)

What percentage of male and female patients (as listed at birth) 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%. Round to the nearest whole number.

31. % Male Patients *

____

32. % Female Patients *

____

33. % 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 percentages add up to 100%.

34. % 0-17 years old: *

35. % 18-64 years old: *

36. % 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%.

37. % Latino or Hispanic *

38. % White or Caucasian *

39. % Black or African American *

40. % Asian or Hmong *

41. % American Indian or Alaska Native *

42. % Native Hawaiian or Pacific Islander: *

43. % Multi-racial or Bi-racial *

44. % Other *

45. % 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 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

46. Below 100% of FPL: *

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

48. Over 200% of FPL: *

Your Patient's Language

49. What percent 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).

50. 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
- [ ] Vietnamese
- [ ] Somali
- [ ] Burmese
- [ ] Rohingya
- [ ] Tibetan
- [ ] ASL
- [ ] Only English

Other: [ ] ______________________

51. Does your clinic 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: [ ] ______________________

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

We recognize that your organization(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.

52. Mark only one oval per row. *

Mark only one oval per row.

	On-Site	Refer Out	Not Available - Planning to add in next 12 monthsNot Available - Would like to add but not currently planned	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

Please answer with regards to this past year.

53. 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 *

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

55. Number of Telehealth Visits *

56. Number of Dental VISITS *

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

57. Number of Mental Health/Behavioral Health VISITS *

58. Number of Pharmaceutical Visits *

59. Number of Case Management/Social Services Visits *

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

61. Of the total MEDICAL visits, approximately what number of MEDICAL visits would have occurred at the ED if the clinic was not in operation? If an estimation cannot be provided, consider surveying patients this question during the visit. *

*Please enter N/A if an estimation cannot be provided

62. Of the total DENTAL visits, approximately what number of DENTAL visits would have occurred at the ED if the clinic was not in operation? If an estimation cannot be provided, consider surveying patients this question during the visit. *

*Please enter N/A if an estimation cannot be provided

63. Does your clinic provide any other services that were not addressed above? If so, please list.

64. Number of In-House Imaging Tests in past year *

*Imaging tests done off-site, but PAID BY THE CLINIC can be counted in the above total. If someone else (i.e., the hospital or radiology center performing imaging test) is donating the services or paying the cost, please do not include this in your totals.

65. Number of In-House Lab Tests in past year *

*Lab draws and lab tests performed on-site can be counted in the above total. Lab tests done off-site, but PAID BY THE CLINIC can be counted in the above total. Lab draws done on-site with lab tests done off-site can NOT be counted towards the total if the clinic does NOT pay for it. If someone else (i.e., the hospital is performing the lab test) is donating the services or paying the cost, please do not include this in your totals.

66. Number of In-House COVID Tests in past year *

*COVID tests done off-site, but PAID BY THE CLINIC can be counted in the above total. If someone else (i.e., the hospital) is donating the services or paying the cost, please do not include this in your totals.

67. Number of COVID Vaccinations in past year provided in your clinic by an outside organization (e.g. the state or local public health department or a private provider) * *

68. Number of COVID Vaccinations in past year provided independently by your clinic (vaccines administered by clinic personnel, not by an outside organization) *

NUMBER OF PATIENTS

69. Total NUMBER of New Patients in Past Year *

*A new patient is someone who is completely new to the clinic or has not been previously seen by the clinic within the past 3 years.

70. Total number of patients served in past year (new and established combined) *

*Note: this is different from total number of visits. A patient could come in multiple times in a year. For this question, this would only count as 1 patient served

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

71. Medical program *

72. Dental program *

73. Mental Health/Behavioral Health *

74. Pharmaceutical *

75. Case Management/Social services (with community health worker) *

76. Other

YOUR PATIENTS MEDICAL CONDITIONS

Of the total number of patients you serve, what percentage of those patients receive the following services (please provide best estimate)? Please use whole numbers (20% instead of 0.20). Note that patients can be counted towards more than one category (have multiple screenings). The sum of the percentages may exceed 100%.

77. % Diabetes Screening/Management *

78. % HTN Screening/Management *

79. % Cancer Screening/Management *

80. % Obesity Screening/Management *

81. % Dental Care *

82. % Sexual Health Screening/Management *

83. % Dyslipidemia/Hypercholesterolemia Screening/Management *

84. % Mental Health Screening/Management *

85. % Influenza Immunization *

*If the clinic is involved in any part of the process of the patient obtaining the vaccine (i.e., providing the vaccine, providing a voucher, or referring the patient to an outside agency), this counts towards this percentage.

86. % Other Immunizations (ex: shingles, pneumonia, COVID, etc) *

*If the clinic is involved in any part of the process of the patient obtaining the vaccine (i.e., providing the vaccine, providing a voucher, or referring the patient to an outside agency), this counts towards this percentage.

STAFF AND VOLUNTEERS

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

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

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

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

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

92. Approximately how many paid employed-hours were worked at your clinic within the past year? Please provide your best estimate. *

93. Approximately how many volunteer-hours were provided at your clinic within the past year? Please provide your best estimate. *

OTHER (Pharmacy, Lab, EMR)

94. Choose what best describes your pharmaceutical facilities. Note: a pharmacy distributes medications packaged from their own bulk supplies, while a dispensary distributes pre-packaged samples and medications. *

Check all that apply.

- [ ] On-site licensed/certificate/permitted pharmacy
- [ ] On-site dispensary

Other: [ ] ______________________

95. What was the total number of 30-day on-site prescriptions filled or medications dispensed by the clinic in the past year. Note that this is different from the number of medications prescribed by the clinic. Please provide your best estimate. *

*Medications that are dispensed at the clinic (via outside programs such as patient assistant programs) but are not paid for by the clinic should NOT be counted in the number of prescriptions. Only medications paid for by the clinic are counted. ex: A three month prescription paid for by the clinic will count as 3 prescriptions.

____

96. Is your organization CLIA certified? *

Mark only one oval.

- ( ) Certified
- ( ) Waived
- ( ) In the process of becoming certified or waived
- ( ) No

97. Does your clinic currently use an Electronic Health Record system? *

Mark only one oval.

- ( ) Yes
- ( ) No
- ( ) In the process of implementing EHR system

98. If yes, or in the process of implementing, which system?

SUMMARY

99. What challenges at your clinic keep you up at night and how can we help?

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

IMPORTANT! PLEASE READ BELOW.

To complete the VHCP 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.)

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