

---

# Welcome to 2026 WAFCC Membership and VHCP Online Portal

WAFCC is pleased to introduce a new Membership and Volunteer Health Care Provider Program (VHCP) online portal, in partnership with the Wisconsin Department of Health Services.

To note:

- Read and review all information on each page for each question.
- Please note that every time you click the **NEXT** button to go to the next screen, all the information you provided on the current screen is **saved**. If you want to go to another screen, you must complete the required files on the current screen first. **Please don't use your browser's back button. You will lose all the information provided.**
- The pages are numbered, which can help you keep track of where you are in the process and help direct us to any issues you might have.
- Click this link for a video walkthrough: [Demo Video](#)

Please have your unique Organization Key ready. This key was sent via email.

If you have questions during the enrollment process, please contact Shelby Miller – [Shelby.Miller@wafccclinics.org](mailto:Shelby.Miller@wafccclinics.org)



To begin, go to the WAFCC website, under the "For Members" tab, click on "WAFCC Membership Renewal and VHCP Enrollment." Then, scroll to the bottom of the page and click on the blue "Enroll Here" button.

---

## Annual Membership and VHCP Enrollment

1. Click the drop-down button and select the option you would like to complete. Click the “Next” button on the bottom right to continue.

WAFCC welcomes you to our online portal, in partnership with the Wisconsin Department of Health Services.

Please Select the Best Option & click NEXT...

\*  
--None--

- You may start / stop your application as necessary. Just be sure to click the NEXT button and your data will be saved.
- If you have questions during the enrollment process, please contact WAFCC Assistance: [assistance@wafccclinics.org](mailto:assistance@wafccclinics.org)

2.

**Please be sure to have your Organization Key, sent by email.**

\* Have you been provided a Unique Organization Key?

Yes- I have our key ready

\* Please enter your Organization Key

2001PtvwAACTESa0s5e000010Z

\* Are you a free and charitable clinic?

Yes

\* Which of the following are you doing today?

VHCP Enrollment and WAFCC Membership

### Form Instructions

- Every time you click the **Next** button to go to a new screen, the information you've provided on the current screen is **saved**.
- If you want to go to a **Previous** screen, you must complete the required fields on your current screen first.
  - This information will be **saved** before you go back to the previous screen.
- Please **do not** use your browser back button. You will lose all the information you provided.
- If you need to leave the form to come back later, be sure to finish your current page and click on **Next** before you close the tab/window or navigate away.
  - If you don't click on **Next**, the information you just entered on that page will **not** be saved (information entered previously or on previous pages has already been saved, however).

If you have previously started an application and are logging back in to continue, you will get a message regarding an in-progress application. By clicking "Next," you will pick up from where you left off in the application process.

We located an in-progress Application for your org for the current year. When you click "Next", that Application will be loaded for you to continue from and/or make edits to.

If you would like to start over with a new Application and abandon the existing one, click "Exit" and please email WAFCC for support at [assistance@wafcclinics.org](mailto:assistance@wafcclinics.org).

Page 2

Exit Next

### Welcome \* Test Organization (Non-FCC)!

Please provide the following information about who is filling out the application today.

\* First Name

Test

\* Last Name

Organization

\* Email

shelby.miller@wafcclinics.org

\* Phone

414-308-6839

Page 3

Next

The first few pages will be contact information. Page one will be the information of the individual filling out the application (see above photo). Page two will be information regarding your organization, including Primary contact details, organization information, and organization address (see photo below).

Thank you for providing your contact information, Test .

Next, please review the following information about your Organization. Make edits to any fields that need to be updated or that are missing information.

#### Organization's Primary Contact Details

\* Organization's Primary Contact Name ⓘ

Shelby Miller

\* Organization's Primary Contact Position/Title ⓘ

Wisconsin Association of Free and Charitable Clinics

\* Organization's Primary Contact Email

shelby.miller@wafcclinics.org

#### Organization Information

\* My organization is considered a:

Charitable Clinic

\* Organization Name

\* Test Organization (Non-FCC)

\* Organization Phone

9202771555

---

Next, you will Provide Financial Data

- a. Federal EIN (Tax ID)
- b. Total Cash-operating expenditure in the past year? Exclude capital spending as well as donated time, goods, and services.
- c. What is the approximate total revenue received from patient fees and reimbursements of services in the past year?
- d. If you receive Third Party Payments.
- e. If your organization charge patients for any services.

## Financial Data

\* Federal EIN (Tax ID)

472298281

My Tax Exempt Status is 501(c)(3)

\* What was your total cash-operating expenditure in the past year? Either your most recently completed fiscal or calendar year (by December 31, 2025). Exclude capital spending as well as donated time, goods, and services.

\$33,333

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

\$33,333

\* Do you receive Third Party Payments?

Yes - Medicaid

\* Does your organization charge patients for any services?

No, we do not accept payment of any kind

**Next, Provide Target Population of Organization / Age / Race Ethnicity and Income Level. All your numbers MUST add up to 100.**

**Target Populations of Organization**

**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%.  
If there is a cell empty after you reach 100%, enter 0.

\* % Male Patients  \* % Female Patients  \* % 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%.  
If there is a cell empty after you reach 100%, enter 0.

\* % 0-17 years old  \* % 18-64 years old  \* % 65+ years old

**Your Patients Race/Ethnicity (%)**

What percentage of your patients identify with one of the following races or ethnicities?  
Please provide best estimate of percentages in the fields below.  
Please make sure percentages add up to 100%.  
If there is a cell empty after you reach 100%, enter 0.

\* % Latino or Hispanic  \* % Asian or Hmong  \* % Multi-racial or Bi-racial   
 \* % White or Caucasian  \* % American Indian or Alaska Native  \* % Other   
 \* % Black or African American  \* % Native Hawaiian or Pacific Islander  \* % 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%.  
If there is a cell empty after you reach 100%, enter 0.

Family Size	2025 Annual FPL	2025 Monthly FPL							
		50%	100%	156%	191%	200%	250%	306%	400%
1	15,650	652	1,304	2,035	2,491	2,608	3,260	3,991	5,217
2	21,150	881	1,763	2,750	3,366	3,525	4,406	5,393	7,050
3	26,650	1,110	2,221	3,465	4,242	4,442	5,552	6,796	8,883
4	32,150	1,340	2,679	4,180	5,117	5,358	6,698	8,198	10,717
5	37,650	1,569	3,138	4,895	5,993	6,275	7,844	9,601	12,550
6	43,150	1,798	3,596	5,610	6,868	7,192	8,990	11,003	14,383
7	48,650	2,027	4,054	6,325	7,743	8,108	10,135	12,406	16,217
8	54,150	2,256	4,513	7,040	8,619	9,025	11,281	13,808	18,050
+add'l	5,500	229.17	458.33	715.00	875.42	916.67	1,145.83	1,402.50	1,833.33

The amounts listed on this screen (effective as of February 1, 2024) are based on federal guidelines, which may change each year.  
See the Wisconsin Department of Health Services website for more information. (<https://www.dhs.wisconsin.gov/medicaid/fpl.htm>)

\* Below 100% of FPL  \* Between 100% and 200% of FPL  \* Over 200% of FPL

**Your Patient's Language**

\* What percent of your patient population does not speak English as their primary language?  
(Please provide best estimate of percentage)

---

## Next, select your Services Provided.

### Services Provided

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.

\*1 Dental Care

\*2 Yearly Physicals

\*3 Chronic Disease Management

\*4 Case Management

\*5 Urgent and/or Acute Care

\*6 Mental Health Treatment/Counseling

\*7 Specialty Services

\*8 Vision Screening

\*9 Laboratory

\*10 X-ray (non-dental)

\*11 Immunizations

\*12 Prenatal and/or Obstetrical Care

\*13 STD Testing/Treatment

\*14 HIV Testing

\*15 Substance Abuse Treatment/Counseling

\*16 Family Planning

If you selected “Onsite” for the Dental Care category, on the following page, you will see the Dental portion pop up on the right-hand side. If you need guidance for what services are included in each Tier, click the “Show Dental Procedures Reference List (Tiers 1-4)” box below the “Total Dental Procedures” box. If you clicked “Do Not Provide” for the Dental Care category, you will not see this.

### Your Patient Dental Visits and Tests

Please answer with regards to this past year.

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

33

\* Total Dental Procedures \*Note: this is different from the number of dental VISITS. One patient could have more than one procedure per visit

33

Show Dental Procedures Reference List (Tiers 1-4)

\* Tier 1 Dental Procedures: Preventative and Diagnostic Services (Of the total dental procedures, how many were classified as Tier 1?)  
Examples: comprehensive oral evaluations, bitewing - single radiographic image, and other preventative or diagnostic services.

33

\* Tier 2 Dental Procedures: Restorative and Non-Surgical Extractions (Of the total dental procedures, how many were classified as Tier 2?)  
Examples: resin-based composite - two surfaces, anterior, and non-surgical tooth extractions.

33

If you clicked “Do Not Provide” for the Dental Care category, you will only have to fill out the Patient Medical Visits and Test portion.

### Your Patient Medical Visits and Tests

Please answer with regards to this past year.

\* 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

3,333

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

3,333

\* Number of Telehealth Visits (Exclude Mental Health/Behavioral Health visits captured below)

3,333

\* Number of Mental Health/Behavioral Health VISITS (1 VISIT = 1 HR)

3,333

\* Number of Pharmaceutical Visits / Medication Management Consults

3,333

\* Number of Case Management/Social Services Visits

3,333

# Number of Patients and Patients Medical Conditions

## Number of Patients

### 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.

### Total number of patients served in past year (BOTH 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:

\* Medical program

\* Mental Health/Behavioral Health

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

\* Dental program

\* Pharmaceutical

\* 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)? Note that patients can be counted towards more than one category (have multiple screenings). The sum of the percentages may exceed 100%.

\* % Diabetes Screening and/or Management

\* % Dental Care

\* % 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.

\* % HTN Screening and/or Management

\* % Sexual Health Screening and/or Management

\* % Cancer Screening and/or Management

\* % Dyslipidemia/Hypercholesterolemia Screening and/or Management

\* % Obesity Screening and/or Management

\* % Mental Health Screening and/or Management

\* % 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.

# Provide Staff and Volunteers

## Staff and Volunteers

### Paid Staff

\* Total Number of Paid Providers:

\* Total Number of Full-time Staff (32+ Hours):

\* Total Number of Part-time Staff (less than 32 Hours):

\* What was the total number of Paid/employed hours for your Clinic this past calendar year:

### Volunteers

\* Total Number of Volunteers:

\* Total Number of Volunteer Providers:

\* What was the total number of Volunteer hours provided at your Clinic this past calendar year:

## Provide Pharmaceutical and Summary information.

### Pharmaceutical

\* 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.

On-site dispensary

\*  
**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.

222

Please enter some valid input. Input is not optional.

\* Is your organization CLIA certified?

Waived

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

Yes

\* Which EHR system?

Athena

### Summary

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

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

Page 11

**Reminder:** You must fill in every required box (demonstrated by a red asterisk \*). If you hit "Next" without filling in the box, it will outline the box in red and remind you to complete it.

### Submission:

Please confirm that you have completed this Application and are ready to submit.

**Once you click Submit, you will be taken directly to the VHCP Enrollment Wizard.**

A WAFCC invoice will be sent to you through our account system, Quickbooks. You will also receive a confirmation email from [shelby.miller@wafccclinics.org](mailto:shelby.miller@wafccclinics.org) with a copy of your responses to the Application for your record and review.

---

## Submission

You've now completed all the required Application questions.

**\*\*\* Once you click on "Submit", you will no longer be able to review or change your responses.**

Please use the "Previous" button to go back through the screens and review your responses if desired before submitting.

**By checking the "Confirmed" box below, my Organization confirms the truth of, acknowledges responsibility for, and agrees to continue to uphold the following statements:**

- The organization is a non profit agency (Free and Charitable Clinic) or non profit school board or governing body providing health care services to students.
- The Volunteer Health Care Provider doesn't receive income from the practice of his or her health profession in the organization.
- The [Volunteer Health Care Provider](#) shall maintain his or her credentials for his or her health care profession.
- As the member of the Organization, I certify that I have verified the credentials for each provider submitted to VHCP coverage through our Organization
- The organization assumes responsibility for approving individuals to be Volunteer Health Care Providers and will:
  - Research and validate an individual's credentials before submitting the joint application to be a Volunteer Health Care Provider.
  - Maintain a list of Volunteer Health Care Providers providing services at the non profit agency in an online portal (hosted by WAFCC).
  - Monitor Volunteer Health Care Providers providing services at the non profit agency and shall terminate a providers participation in the program when the agency questions the credentials of the provider or when the agency disapproves of the practices of the provider.

**Also, by checking the "Confirmed" box below, my Organization acknowledges and understands WAFCC/DHS' Data Use for Collaborative Purposes Acknowledgment**

- By checking the box below and submitting data to Wisconsin Association of Free and Charitable Clinics Inc ("WAFCC"), [entity name or however you reference clinic throughout the rest of the data sheet] ("Organization"), acknowledges and agrees that WAFCC may use aggregate organizational data for collaborative WAFCC purposes, including but not limited to, group purchasing agreements or vendor contracts, preparing reports for members and third-parties (required by WI DHS for VHCP), supporting advocacy efforts, enhancing member services, or other purposes subject to applicable law. WAFCC will maintain confidentiality of clinic-specific data, except when disclosed in aggregate form, required by law, or shared with third parties under confidentiality obligations to accomplish these purposes.

**Lastly, by checking the "Confirmed" box below, I confirm that I have completed the survey accurately to the best of my knowledge for my Organization and I have read and understand the Disclaimer.**

(once confirmed, you can go ahead and click the **Submit** button)

Confirmed

*After clicking on "Submit", you will be taken directly to the VHCP Enrollment Wizard.*

You should also receive a confirmation email at [shelby.miller@wafccclinics.org](mailto:shelby.miller@wafccclinics.org) listing your responses to the Application questions for your record and review.

Thank you for providing valuable data. Next, you will receive an invoice from WAFCC. Thank you in advance for your payment.

In the meantime, if you have any questions please contact: [assistance@wafccclinics.org](mailto:assistance@wafccclinics.org).

---

## VHCP Enrollment

The Wisconsin State Statutes define the Volunteer Health Care Provider and eligibility for participation in the program. Please check the box to the left of the bullet points to acknowledge your organization's commitment and agreement to the following criteria. For more information visit [Wisconsin Legislature: 146.89](#)

### Welcome to VHCP Enrollment!

The Wisconsin State Statutes define the Volunteer Health Care Provider and eligibility for participation in the program. Please check the **box to the left of the bullet points** to acknowledge your organization's commitment and agreement to the following criteria. For more information visit [Wisconsin Legislature: 146.89](#)

**By checking the "Confirmed" box below, my Organization confirms the truth of, acknowledges responsibility for, and agrees to continue to uphold the following statements:**

- The organization is a non profit agency (Free and Charitable Clinic) or non profit school board or governing body providing health care services to students.
- The Volunteer Health Care Provider doesn't receive income from the practice of his or her health profession in the organization.
- The [Volunteer Health Care Provider](#) shall maintain his or her credentials for his or her health care profession.
- As the member of the Organization, I certify that I have verified the credentials for each provider submitted to VHCP coverage through our Organization
- The organization assumes responsibility for approving individuals to be Volunteer Health Care Providers and will:
  - Research and validate an individual's credentials before submitting the joint application to be a Volunteer Health Care Provider.
  - Maintain a list of Volunteer Health Care Providers providing services at the non profit agency in an online portal (hosted by WAFCC).
  - Monitor Volunteer Health Care Providers providing services at the non profit agency and shall terminate a providers participation in the program when the agency questions the credentials of the provider or when the agency disapproves of the practices of the provider.

**Also, by checking the "Confirmed" box below, my Organization acknowledges and understands WAFCC/DHS' Data Use for Collaborative Purposes Acknowledgment**

- By checking the box below and submitting data to Wisconsin Association of Free and Charitable Clinics Inc ("WAFCC"), [entity name or however you reference clinic throughout the rest of the data sheet] ("Organization"), acknowledges and agrees that WAFCC may use aggregate organizational data for collaborative WAFCC purposes, including but not limited to, group purchasing agreements or vendor contracts, preparing reports for members and third-parties (required by WI DHS for VHCP), supporting advocacy efforts, enhancing member services, or other purposes subject to applicable law. WAFCC will maintain confidentiality of clinic-specific data, except when disclosed in aggregate form, required by law, or shared with third parties under confidentiality obligations to accomplish these purposes.

**Lastly, by checking the "Confirmed" box below, I confirm that I have completed the survey accurately to the best of my knowledge for my Organization and I have read and understand the Disclaimer.**

(once confirmed, you can go ahead and click the **Submit** button)

## Instructions

1. Review and update your current list of providers.
  - a. Check name, title and status. Hover over the field and click the icon pencil to update.
  - b. A save button will appear once you make the edit.
  - c. After editing a field the background changes from white to yellow to remind you to save your work before moving to another screen.

Instructions

1. Review and update your current list of providers.
  - a. Check name, title and status. Hover over the field and click the icon pencil to update.
  - b. A save button will appear once you make the edit.
  - c. After editing a field the background changes from white to yellow to remind you to save your work before moving to another screen.
2. Scroll to the bottom of the page to add new providers.
  - a. Select 'Yes - I need to add a new provider(s)' from the dropdown.
  - b. Add one provider at a time and click submit.
  - c. The providers you add will populate in your current list of VHCP providers.
3. Your changes will be saved when you click submit.

Your Current Active VHCP Providers (Click here to hide/show this section)

Provider Name (FirstName LastName)	Title	Status ↑
1 Provider Test	Physical therapist	Active
2 Monica Kampschroer	Chiropractor	Active
3 John Smith	Social worker	Active
4 Dr. Dermatology	State-licensed physician	Active

Cancel Save

d.

2. Scroll to the bottom of the page to add new providers.
  - a. Select 'Yes - I need to add a new provider(s)' from the dropdown.
  - b. Add one provider at a time and click submit.
  - c. The providers you add will populate in your current list of VHCP providers.

Do you need to add a new VHCP Provider(s)? ?

Yes- I need to add a new Provider(s)

Provider Name (First Name Last Name) Title

--None--

Once you've completed this enrollment wizard and arrive at the final screen, a list of all active VHCP Providers on file for your organization will be sent to the Organization Email we have on record. You may also specify an additional email address in the following field to receive this email. We will also document today as the most recent date that your organization has updated their VHCP information. By selecting "Yes- please email me our list of active providers after I click Submit" and clicking on the "Submit" button, you will receive an email listing your current active VHCP Providers.

Additional Confirmation Email Recipient

you@example.com

Are you finished making changes? ?

Yes- please email me our list of active providers after I click Submit

Please be sure to click Submit to save your changes.

Your changes will be saved when you click submit.

