



2010 Membership Application (\$50.00) Check appropriate category

____ **NEW CLINIC MEMBERSHIP** Please enclose: 1. A copy of your 501(c) (3) IRS determination letter; 2. A copy of your Bylaws; and 3. A check to LSACC for \$50.00.

Charitable Clinic Membership is available to community-based organizations that:

1. Have an independent governing body composed of broad representation from the community;
2. Have 501(c) (3) tax-exempt recognition from the Federal Internal Revenue Service, or has applied for such status or is a program component of a larger 501(c) (3) organization that provides other services;
3. Are committed to providing quality health care services or healthcare related support services to the unserved and underserved while minimizing barriers to such care; and
4. Have a varied base of community support that includes individuals, businesses, churches, foundations and government and utilizes volunteers.

____ **RENEWAL CLINIC MEMBERSHIP** Enclosed is \$50 dues. 501(c) (3) IRS determination letter and Bylaws have been provided. I am renewing a clinic membership.

____ **ASSOCIATE NON-VOTING MEMBERSHIP:** Available to any organization or person supporting LSACC. Enclosed is a check to LSACC for \$50.00.

Name of Organization: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Executive Director: _____

Contact Person: _____ Title of Contact: _____

Email (s) to receive notices: 1. _____ 2. _____

In order to better advocate for Texas Clinics, please fill in the blanks below for the most recent or current year (or last 12 months), if possible:

Annual Year Budget: _____ # Unduplicated Patients: _____ # Patient Visits: _____

No. of Volunteers: _____ No. of Vol. Hrs. _____ No. of Paid Staff; Full Time: _____ Part Time: _____

No. of Volunteer Physicians: _____ Specialty Referral Services Available: (List specialists) _____

Are you "deemed" for FTCA coverage: ___Yes ___No

Are your services: ___ Free; ___ Donation only; ___ Sliding Scale (with inability to pay no barrier to service) ___ Other: please specify _____

Program Information: (Check all that apply) ___ Medical (# hours per week _____) ___ Rx's; ___ Dental; ___ Mental Health; ___ Diabetes/Hypertension Education; ___ Other: please specify _____

Make checks payable to LSACC and send with this form to: LSACC, PO Box 684127, Austin, TX 78768-4127. For questions or additional information, please call (830) 992-7492, visit the website: www.tx-lsacc.org

LSACC Use Only: Date Received: _____ Amount: _____ Check #: _____