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| --- | --- |
| Full-color_on_light_stacked  | **Community Health Center** Loan Application* *For financing community health center facilities (FQHCs, FQHC look-alikes, and on a case by case basis other health centers/ programs) - acquisition, renovation, construction and leasehold improvements*
* *$100 non-refundable application fee*
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| --- |
| Community Health Center (CHC) |
| **Name**  | **Federal Tax ID #** |
| **FQHC Status \_\_\_** FQHC \_\_\_ FQHC Look-Alike \_\_\_ Other: **Date Incorporated**  |
| **Corporate Affiliation with** | **Describe Affiliation** |
| **Address** |
| **City** | **State** | **Zip** |
| Phone | **Fax** | **Website** |
| Contact PersonTitle | **Phone****Email** |

|  |
| --- |
| Applicant / Borrower *(if different from CHC)* |
| **Legal Name** | **Federal Tax ID #** |
| **Address** |
| **City** | **State** | **Zip** |
| Phone | **Fax** | **Website** |
| Contact PersonTitle | **Phone****Email** |

|  |
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| Loan Request |
| **Loan Amount $ Loan Term (Months)** Construction: \_\_\_\_\_\_ Permanent: \_\_\_\_\_\_ |
| **Loan Use (Check all that apply):** \_\_\_ Land Acquisition \_\_\_ Facility Acquisition \_\_\_ New Construction\_\_\_ Renovation \_\_\_ Expansion\_\_\_ Equipment Purchase \_\_\_ Refinance Existing Debt \_\_\_ Other |

|  |
| --- |
| **References** *(Able to discuss your organization’s financial experience and/or programs. Include a contact from the state primary care association or other relevant references, such as representatives from a regional consortium.)* |
| **Name**  | **Organization** | **Phone** |
| **1.** |  |  |
| **2.** |  |  |
| **3.** |  |  |
| **Loans and Other Financing Currently Outstanding** |
| **Name of Creditor**  | Amount | Purpose | Status |
| **1.** |  |  |  |
| **2.** |  |  |  |

|  |
| --- |
| Facility to be Financed |
| Address  |
| City | State | Zip |
| Square footage of completed building? |
| Will project increase the amount of physical space available to deliver health services? Yes / No

|  |  |  |  |
| --- | --- | --- | --- |
| If yes, | Area | Current Sq Ft | Projected Sq Ft |
|  | Medical |  |  |
|  | Dental |  |  |
|  | Laboratory |  |  |
|  | Administrative |  |  |
|  | Other - |  |  |
|  | Common Area |  |  |
|  | Total |  |  |

 If yes, how many additional patients can be accommodated? \_\_\_\_\_\_\_\_\_\_ vs. \_\_\_\_\_\_\_\_\_\_ previously |
| Applicant (select) \_\_\_ Owns? \_\_\_ Leases? \_\_\_ Has the facility under a Sales Agreement? |
| **Is value known? Yes / No Value $ How was value determined?** Can Lender place a First Mortgage on the property to secure this loan? Yes / No If not, is a subordinate mortgage or other collateral available? Please explain.Will the facility also be used by other organizations or for other community purposes? Yes / No **If yes, describe:** |

**To complete the application, please attach *all* of the following items:**

###### Application Fee

* Check for $100 application fee made payable to The Reinvestment Fund or Low Income Investment Fund *(see page 6 for submission instructions)*

##### CHC: Organizational Information

* Brief history of the CHC and founding group (include annual reports, brochures, newsletters, etc).
* If CHC is affiliated with a hospital or health network, please describe the affiliation.
* Service area by geography (county, city, census tracts) and population.
* Current and projected patients served with description, by percentage, of target population by income level (<100% Federal Poverty Level (FPL), 100%-200% FPL, <200% FPL), uninsured status and race/ethnicity.
* Evidence of unmet medical needs and demand for services in service area.
* Organizational chart and resumes for key staff members. For start-ups, please include staffing plan.
* List of Board of Directors. Indicate each member’s gender, race/ethnicity, address and occupation or area of expertise.
* Copy of 501(c)3 tax status determination letter.
* Copy of Articles of Incorporation and Corporate Bylaws.
* Copy of last three Board meeting minutes.
* Copy of latest Notice of Grant Award for Section 330 grant or the FQHC Look-Alike Designation Memo (if applicable).
* Copy of report from HRSA’s latest site visit.

##### CHC: Financial Information

* Organizational budget for the current fiscal year and next fiscal year, if available.
* 10-year operating projections. Include detailed utilization and reimbursement information by payor based on users, encounters and rates. Include provider FTEs and productivity by service. Include written assumptions for projected line items.
* Financial audits for the last three fiscal years.
* Most recent month’s year-to-date financial statements (unaudited) with comparison to budget.

##### Health Service Information

**Hours of Operation**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Total |
| Existing |  |  |  |  |  |  |  |  |
| Planned |  |  |  |  |  |  |  |  |

**Service Areas**

|  |  |  |
| --- | --- | --- |
|  | **Current** | **Projected** |
| # of Medical Exam Rooms |  |  |
| # of Dental Operatories |  |  |

**Utilization – Historical/Current/Projected – Users/Encounters**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Fiscal Year Ended:** |  |  |  |  |  |  |
|  | *-3 Years* | *-2 Years* | *-1 Year* | *Current* | *+1 Year* | *+2 Years* |
| **Payor** | *Users/Encntrs* | *Users/Encntrs* | *Users/Encntrs* | *Users/Encntrs* | *Users/Encntrs* | *Users/Encntrs* |
| Medicaid | / | / | / | / | / | / |
| Medicare | / | / | / | / | / | / |
| Self Pay | / | / | / | / | / | / |
| Free Care | / | / | / | / | / | / |
| Commercial | / | / | / | / | / | / |
|  |  |  |  |  |  |  |
| Capitation-Medicaid | / | / | / | / | / | / |
| Other - | / | / | / | / | / | / |
| Other - | / | / | / | / | / | / |

##### Health Service Information (continued)

# Services Offered – Current and Upon Completion of Proposed Project

 Current Proposed

|  |  |  |  |
| --- | --- | --- | --- |
|  | Adult Medicine |  | Adult Medicine |
|  | Ambulatory Surgery |  | Ambulatory Surgery |
|  | Dental |  | Dental |
|  | Elder Care and/or Geriatric Medicine |  | Elder Care and/or Geriatric Medicine |
|  | Family Planning |  | Family Planning |
|  | Home Care |  | Home Care |
|  | Laboratory |  | Laboratory |
|  | Mental Health |  | Mental Health |
|  | Nutrition |  | Nutrition |
|  | OB/GYN |  | OB/GYN |
|  | Occupational Health |  | Occupational Health |
|  | Pediatrics |  | Pediatrics |
|  | Pharmacy |  | Pharmacy |
|  | Podiatry |  | Podiatry |
|  | Radiology |  | Radiology |
|  | Substance Abuse |  | Substance Abuse |
|  | Urgent Care |  | Urgent Care |
|  | Vision testing |  | Vision testing |
|  | Physical Therapy |  | Physical Therapy |
|  | Other: |  | Other: |
|  | Other: |  | Other: |

##### Affiliated Organization as Borrower, Co-Borrower or Guarantor (If applicable)

##### If the CHC has a sponsor or affiliated organization that will be the Borrower, Co-Borrower or Guarantor for this loan, please also include the following information:

|  |
| --- |
| Which entity will own the real estate? Is affiliate a 501(c) 3 organization? Yes / NoIs affiliate going to be the Borrower? Yes / No If No, is affiliate willing to be co-borrower? Yes / No If No, is affiliate willing to guarantee the loan? Yes / No  |

* Brief history of affiliated organization (include annual reports, brochures, newsletters, etc).
* Description of who is served by affiliated organization (mission, target geographic area).
* Description of connection to and involvement with CHC.
* Organizational budget for current fiscal year and next fiscal year, if available.
* Financial audits for the last three fiscal years.
* Resumes of key staff and organizational chart.
* List of Board of Directors. Indicate each member’s gender, race/ethnicity, address and occupation or area of expertise.
* Copies of last three Board meeting minutes.
* Copy of Articles of Incorporation and Corporate Bylaws.
* Contact information if not listed on application’s cover page.

##### Project Information

* Description of facility project (as-is condition, scope of work, how its design and location serve the needs of the CHC) and Applicant’s previous experience with similar projects.
* Project timeline, including regulatory approval milestones
* Copy of lease, agreement of sale or deed showing site control or ownership of property (whichever is applicable).
* Sources & uses of funds, including project budget *(see attached sample)* and explanation of how budget was determined. Please attach copies of award letters or commitments for any grants or other funding sources and bids for any of the project costs, if available.
* Resume and qualifications for internal staff who will oversee the project.
* List of project team and their qualifications: project manager, architect, general contractor, consultants.
* Copy of appraisal and environmental reports , if available.

# Signature and Authorization

The undersigned applicant(s) do hereby represent and warrant that the information contained on this form, and any attachments submitted in conjunction with this application, is complete and correct and accurately describes the health center and the proposed project. Applicant(s) agree to promptly inform Reinvestment Fund of any relevant changes in the proposed/actual project or the information submitted for this financing application. Furthermore, the applicant(s) warrants that, within any guidelines mandated by the Health Resources & Services Administration (HRSA), it will ensure equitable access by all patients, regardless of gender, race, national origin, color, disability or age.

Furthermore, applicant(s) authorize Reinvestment Fund and/or any of its subsidiaries or affiliates to obtain credit references and credit reports on the business and to release credit information to others. All applications are subject to final credit approval. Reinvestment Fund and its affiliates reserve all rights to publicly announce the approval, commitment or closing of any loan.

By: By:

Title: Title:

Date: Date:

###### Questions?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Bridget WiedemanReinvestment Fund(215) 574-5857bridget.wiedeman@reinvestment.com www.reinvestment.com |  |  |  |  |

###### To Submit: Mail completed application, application fee and supporting documentation to:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Reinvestment Fund1700 Market Street, 19th FloorPhiladelphia, PA 19103-3904Attention: Bridget Wiedeman |  |  |  |  |

###### Email submission of supporting documentation is encouraged.

###### Email to: bridget.wiedeman@reinvestment.com