

California Health Center Emergency Working Capital Loan Program

Eligible Borrowers shall have been in existence for at least 3 years prior to application to the program and shall be either (a) private, not-for-profit corporation that operates one or more primary care or family planning clinics licensed by the State of California under Section 1204 of the California Health and Safety Code; or (b) a clinic operated in California by a federally recognized Indian tribe located on land recognized as tribal land by the federal government.

Maximum loan amount:	The lesser of \$750,000 or up to 90% of the amount of anticipated delayed payments, as evidenced by a recent four-week period of Medicaid warrant amounts (see application for required documentation). Maximum loan amount is per corporate entity.
Purpose:	To bridge delays in the receipt of Medi-Cal payments (March 2009).
Maturity:	No later than May 1, 2009, unless Medi-Cal payments are further postponed.
Repayment:	Accrued and unpaid interest only with the full balance of principal and any remaining accrued interest due upon note maturity.
Interest rate:	approximately 4.5%
Origination Fee:	.25% of approved loan amount
Borrower's costs:	\$250 application fee (credited towards origination fee at loan closing) \$150 documentation fee
Collateral:	UCC filing
Prepayment:	Loan may be prepaid in whole or in part at any time during the loan term.

Contact:
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NCB Capital Impact
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EMERGENCY WORKING CAPITAL LOAN APPLICATION

APPLICANT INFORMATION		
Business Name	Street Address	
City	State	Zip
Telephone Number	Tax I.D. Number	
Contact Name	Contact Title	
Fax Number	Email Address	
Service Area		
Geographic Area(s) Served (i.e., City, County, Region)		Date of Inception
Number of primary care sites	Please place a check if your health center is a: <input type="checkbox"/> FQHC <input type="checkbox"/> 330 Grantee	
Eligibility		
The clinic is (check one):	<input type="checkbox"/> A private, not-for-profit corporation that operates one or more primary care or family planning clinics licensed by the State of California under Section 1204 of the California Health and Safety Code.	
	<input type="checkbox"/> A private, not-for-profit consortium with majority membership comprised of primary care or family planning clinics licensed by the State of California under Section 1204 of the California Health and Safety Code.	
	<input type="checkbox"/> A clinic operated by a federally recognized Indian tribe and which is located on land recognized as tribal land by the federal government.	

AMOUNT OF BORROWING REQUEST
<i>Please also provide the written confirmation requested in the "List of Attachments" Section</i>
Total Medi-Cal warrant amount for recent 4-week period \$
Calculation of 90% of total Med-Cal warrant amount => Eligible Borrowing Request: \$

DESCRIPTION OF NEED			
YOUR COMMUNITY HEALTH CENTER			
Please provide the following as of the year end for the 3 most recent years.	_____	_____	_____
Number of FTEs			
Number of Patients			
Number of Encounters—Medicaid			
Number of Encounters—Sliding Fee Scale			
Number of Encounters—Fee For Service—Private Pay			
Number of Encounters--Medicare			
Number of Encounters—All Other			
Number of managed care lives (fee for service)			
Number of managed care lives (capitation)			
Amount of PPS Rate (if applicable)			
Amount of 330 grant (if applicable)			

FINANCIAL SUMMARY
Please provide detailed information on any changes in revenues (payor sources or client make-up) or expenses as well as any significant changes to cash position or leverage. If you have had losses during the last 3 years, please briefly discuss any contributing factors.
Are you aware of any pending/future prior period adjustments (disallowances)? If so, please detail here.

List of Attachments

Please provide the following corporate and financial information:

- A copy of your clinic’s Articles of Incorporation and Corporate By-laws
- Bio or resume for CEO/Executive Director and CFO/Finance Manager
- A copy of the last three years’ financial statements, which must have been either audited or reviewed by an independent Certified Public Accountant
- A copy of internally-prepared financial statements for the most recent interim period.

To evidence the receivable amount that will be owed, please provide the following:

- **Remittance advice (RA) cover sheets detailing the Med-Cal Financial Summary (warrant amounts) for each clinic site over a recent 4 week period.** Loans will be considered for up to 90% of this total amount (up to \$750,000) as a proxy for the March checkwrite delay.

**Remember to include a check for the \$250 application fee to:
“NCB Capital Impact”.**

CPCA loan fund management may check bank, credit and trade references in reviewing this request, and each reference is authorized to discuss with CPCA loan fund management its credit experience with the applicant, as authorized by law. CPCA loan fund management is authorized to discuss with others its credit experience with applicant and other related information. I/We certify that everything in this application and information submitted with this request is true.

SIGNATURE
By: _____
X _____
Date _____
Its _____

Send completed application package to:
 NCB Capital Impact
 CPCA Emergency Loan Program
 1333 Broadway, Ste.602
 Oakland, CA 94612

Questions?
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