



CPCA VENTURES | LOAN APPLICATION FORM

APPLICANT INFORMATION			
Business Name:	Street Address:		
City:	State:	Zip:	
Telephone Number:	Tax I.D. Number:		
Fax Number:	Email Address:		

ELIGIBILITY	
The organization 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.

LOAN REQUEST		
Requested Loan Amount: maximum \$1,000,000 per organization	Loan Category: Please check one box below <input type="checkbox"/> Capital Loan <input type="checkbox"/> Working Capital Loan	Repayment Term: maximum 5 years for Capital Loans and 3 years for Working Capital Loans [] Years

PROJECT DESCRIPTION	
Please provide a brief description of your project and explain the loan purpose. Include objectives, advantages and challenges that the project will bring to your organization. If the loan is to finance a facility project, include the address of the property, explain if it is the renovation of an existing building or a ground up construction, provide details on the status of the project (development/construction/operation), the size of the facility and the intended use (number of exam rooms , type of services, and target population). If the loan is to finance equipment, provide a detailed description of the equipment that will be financed by the loan and clarify if the purchase will be completed before or after the closing of the loan. If the loan is to finance working capital, explain the need for financing, explain how the loan was sized and how it will be repaid (e.g. Receivables).	
Square footage financed (if applicable):	Number of jobs created (if applicable): - construction jobs: - permanent jobs:

SOURCES & USES OF FUNDS			
Sources:	Amount (\$):	Uses:	Amount (\$):
CPCA Loan		Real Estate Acquisition	
Clinic cash on hand		Construction Costs	
Grants *		Soft Costs	
Loans *		Equipment Purchase	
Other Sources (please list)		Contingency/Reserves**	
		CPCA Loan Fees	
		Other (please list)	
Total Sources:		Total Uses:	
* Please clarify the sources of grants and loans for your project and indicate if the funds are committed. ** We typically recommend to include a 10% hard cost contingency and 5% soft cost contingency for facility projects.			

OPERATIONS			
Please check if your health center is: <input type="checkbox"/> FQHC <input type="checkbox"/> 330 GRANTEE		Date of Inception:	
Please check if your health center: participates in the 340B program: <input type="checkbox"/> collocated with senior housing or other senior support services <input type="checkbox"/>		Other community programs and services offered:	
Number of clinic sites:		Types of Health services provided:	
Please provide the following for the 3 most recent fiscal years.		FY	FY
Number of FTEs			
Number of Providers			
Provider Productivity Rate			
Provider Retention Rate			
PPS Rate			
Amount of 330 Grant			

PATIENTS AND ENCOUNTERS			
Please provide the following for the 3 most recent fiscal years.	FY	FY	FY
Number of Patients:			
% Patients – White			
% Patients – Hispanic			
% Patients – Black/African American			
% Patients –Native American/American Indian			
% Patients – Asian/Pacific Islander			
% Patients – Multi Race			
% Patients - Other			
% Patients - Women			
% Patients – age 50 and older			
% Patients – Senior (age 65 or older)			
% Patients – Children (age under 19)			
% Patients – Persons with disabilities			
Number of Encounters :			
% Encounters—Medicaid			
% Encounters--Medicare			
% Encounters—Private Insurance			
% Encounters—Other Public Insurance			
% Encounters—Uninsured			

SERVICE AREA	
Service area (i.e. City, County, Region):	Service area characteristics:
Number of Medicaid eligible individuals in service area:	Health Professional Shortage Area Score:
List any entities in your area that provide similar services to your target population and briefly assess the strengths and weaknesses of these entities:	
Describe any existing, new or emerging competition or other factors that may have a material positive or adverse effect on your operations:	

REVENUES AND EXPENSES

Please explain any significant changes in your revenue makeup or trends:

Please explain any significant changes in your expense categories or trends:

If you received capital grants in the last 3 years, please provide the amount for each year, where they are recorded in your income statement, what is the source and purpose for these grants:

If you had any losses in the last 3 years, please explain the contributing factors and measures taken to return to sustainability:

Please use this space to comment on other variations or elements of your financial statements that may require clarification:

ASSETS AND LIABILITIES

Please explain any increases in accounts receivable and complete table below:

Total A/R as of most recent fiscal quarter	Date	% Aged Less than 30 Days	% Aged 31-60 Days	% Aged 61-90 Days	% Aged Over 90 Days

Please explain any increases in fixed assets in the last 3 years and how they were financed:

Please list all the sources of debt you currently have on your balance sheet:

Lender Name:	Loan Amount Outstanding:	Maturity Date:	Monthly Payment:	Purpose:

List of Attachments

- Executed and complete Application Form
- Copy of your Articles of Incorporation
- Copy of your Bylaws
- Resumes of senior management (Executive Director, Chief Financial Officer or Equivalent, Medical Director, Information Systems Director or Equivalent)
- Resume(s) of the Individual(s) responsible for implementing the project (for facility projects only)
- List of names and occupations of all board members
- Copy of your last 3 years' financial statements, which must have been either audited or reviewed by an independent Certified Public Accountant (include income statement, balance sheet, cash flow statement and audit report)
- Copy of internally-prepared most recent year-to-date financial statements
- Copy of most recent UDS report
- Copy of your budget for the current fiscal year
- Strategic plan (if applicable)
- Complete IRS W-9 form (form available for download at www.irs.gov)

CPCA Ventures loan fund management may check bank, credit and trade references in reviewing this request, and each reference is authorized to discuss with CPCA Ventures loan fund management its credit experience with the applicant, as authorized by law. CPCA Ventures 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.

SIGNATURES	
By _____ Its: Date:	By _____ Its: Date:

The CPCA Ventures Loan Program is administered by Capital Impact Partners, a certified Community Development Financial Institution (CDFI). Capital Impact Partners intends to respond to loan applications with an approval or denial within 2 weeks of receipt of complete applications and to fund approved loans within 1 week of approval. To learn more about Capital Impact Partners, please visit www.capitalimpact.org.



Send Completed Application Package to:
 Capital Impact Partners
 CPCA VENTURES LOAN PROGRAM
 360 22nd Street, Suite 320
 Oakland, CA 94612

Questions?
 Contact Fathia Macauley
 (510) 496-2217 | fmacauley@capitalimpact.org