Indiana Association for Home & Hospice Care

2013 Voting Membership Application - Home Health & Hospice

Step One: Company Information for Main Location

Provider/Company Name: _____

Primary Contact Person *(Person authorized to cast ballots on behalf of organization)*: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **Company E-Mail:** _____

Fax: (_____) _____ **Primary Contact Email:** _____

Toll Free Phone: (_____) _____ **Website:** _____

Number of Employees: FT: _____ PT/PRN: _____

This location offers the following types of services:
(Please check ALL that apply)

- ❑ Home Health
- ❑ Hospice
- ❑ Personal Services (Non-medical)
- ❑ Business Office Only (No services from this office)

Type of Agency:
(Please check ONE only)

- ❑ Certified - Home Health
- ❑ Certified - Hospice
- ❑ Certified - Medicaid Only
- ❑ Licensed Home Health Only
- ❑ Not Licensed - Will Apply

This organization accepts (Please check all that apply): ❑ CHOICE ❑ Commercial ❑ Medicaid ❑ Medicare ❑ Private Pay ❑ Waiver ❑ VA

Please check the counties that <u>this location</u> serves:

❑ Adams	❑ Crawford	❑ Fulton	❑ Jasper	❑ Marion	❑ Parke	❑ Spencer	❑ Wabash
❑ Allen	❑ Daviess	❑ Gibson	❑ Jay	❑ Marshall	❑ Perry	❑ Starke	❑ Warren
❑ Bartholomew	❑ Dearborn	❑ Grant	❑ Jefferson	❑ Martin	❑ Pike	❑ St. Joseph	❑ Warrick
❑ Benton	❑ Decatur	❑ Greene	❑ Jennings	❑ Miami	❑ Porter	❑ Steuben	❑ Washington
❑ Blackford	❑ DeKalb	❑ Hamilton	❑ Johnson	❑ Monroe	❑ Posey	❑ Sullivan	❑ Wayne
❑ Boone	❑ Delaware	❑ Hancock	❑ Knox	❑ Montgomery	❑ Pulaski	❑ Switzerland	❑ Wells
❑ Brown	❑ Dubois	❑ Harrison	❑ Kosciusko	❑ Morgan	❑ Putnam	❑ Tippecanoe	❑ White
❑ Carroll	❑ Elkhart	❑ Hendricks	❑ LaGrange	❑ Newton	❑ Randolph	❑ Tipton	❑ Whitley
❑ Cass	❑ Fayette	❑ Henry	❑ Lake	❑ Noble	❑ Ripley	❑ Union	
❑ Clark	❑ Floyd	❑ Howard	❑ LaPorte	❑ Ohio	❑ Rush	❑ Vanderburgh	
❑ Clay	❑ Fountain	❑ Huntington	❑ Lawrence	❑ Orange	❑ Scott	❑ Vermillion	
❑ Clinton	❑ Franklin	❑ Jackson	❑ Madison	❑ Owen	❑ Shelby	❑ Vigo	

Please check the services that this location provides:

❑ Attendant Care	❑ Home Medical Equipment	❑ Pediatrics	❑ Skilled Nursing
❑ Cardiac Care	❑ Hospice	❑ PERS	❑ Speech Therapy
❑ Companion Care	❑ Infusion Therapy	❑ Physical Therapy	❑ Telehealth
❑ Diabetic Care	❑ Maternal/Child	❑ Respiratory Care	❑ Wound Care Management
❑ Home Health Aide	❑ Medical Social Worker	❑ Respite Care	❑ Other _____
❑ Home Maker	❑ Occupational Therapy	❑ Sitter	_____

Step Two: Additional Locations (See Page 3 - optional)

Please use the attached sheet to identify all additional locations. Please note that additional locations are locations that share your agency's tax ID number and you agree to include their revenue when determining your dues. If an additional location has its own tax ID number, it does not qualify to be an additional location and must join as a Voting member.

Step Three: Additional Staff (See Page 4 - optional)

Please use the attached sheet to identify additional staff that you would like to receive correspondence from IAHHC. This will also make online event registration easier as your employees will already be in the system.

By this signature, I verify that the information provided on this application form is, to the best of my knowledge, correct. I understand that the membership benefits that we receive are only to be used by the company/provider listed in Step One and Two and its employees. Furthermore, I understand that these benefits may not be transferred to another licensed agency or business, which does not hold membership in this association. Any misuse of membership rights and benefits may result in the termination of our membership. I am aware that information on contacting my company will be available for viewing by the public on the IAHHC website. **FCC Communication Consent:** I understand that by providing my mailing address, email address, telephone number, and fax number, I consent to receive communications via regular mail, email, telephone, and/or fax sent by or on behalf of Indiana Association for Home & Hospice Care (IAHHC).

_____ _____

Administrator or Contact Person Date

Step Four: Calculate Your Dues

2012 Revenue Less Contractuals	2013 Dues
New Member Rate**	$ 735
$1 - $250,000	$ 751
$250,001 - $500,000	$ 919
$500,001 - $1,500,000	$ 1,544
$1,500,001 - $2,500,000	$ 3,077
$2,500,001 - $3,500,000	$ 4,568
$3,500,001 - $4,500,000	$ 6,048
$4,500,001 - $5,500,000	$ 7,523
$5,500,001 - $7,500,000	$ 8,946
$7,500,001 - $10,000,000	$ 9,933
$10,000,001 & Up	$ 10,500
Membership extends one year from the month you join.	

Your IAHHC dues will be based on your previous 12 months collected revenue generated from all Indiana business for entities under common ownership, control or board direction, generated from home health services, hospice, personal care/attendant services, companion/sitter services, extended care services and/or therapy services.* If you list any additional locations under your agency, you must include their revenue as well.

Note: *Contributions to IAHHC are not deductible as charitable contributions for federal income tax purposes. However, 88% of your dues payment is deductible as an ordinary and necessary business expense. The Omnibus Reconciliation Act of 1993 provided that a taxpayer would no longer be able to deduct lobbying expenses. This means that the portion of dues directed to lobbying expenses is not deductible by the member/taxpayer. For 2013, we estimate this to be 12% of your dues payment.*

**To view your previous year's dues, the primary contact listed on page one may log in to www.iahhc.org and choose 'Update My Profile' to access organization information.*

***The new member rate is available only for new start-up agencies and agencies that have not been IAHHC members in the past. "New" members exclude those agencies that were members in 2010, 2011 or 2012 and have been acquired or combined under a new organization.*

Installment payment plans are available; eligibility will be determined by IAHHC at time of need. Contact IAHHC's Membership Coordinator at (317) 775-6675 for more information.

Step Five: Payment Information *(Payment MUST accompany application)*

Provider/Company Name: _____

2013 Membership Dues Level: $ _____

Method of Payment

☐ Check (Made payable to IAHHC)
☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: ___ ___ / ___ ___ Security Code: ___ ___ ___

Card Holder's Name *(please print legibly)*: _____

Contribute to Hoosiers Helping Home & Hospice Care PAC for Political Action & Public Education*: $ _____

**Contributions to the PAC are optional, however a $50 donation is recommended.*

There are three ways to submit your application:

Mail: Indiana Lockbox Operations - INHP10
45 North Pennsylvania Street
Indianapolis, IN 46204

Fax: (317) 775-6674

Register Online: www.iahhc.org

Payment Summary:

Amount Due: $_____

PAC Contribution *(optional)* $_____

Total Amount Enclosed: $_____

For IAHHC Use Only

Date Paid ___ ___ /___ ___ / 20____

Amount Paid $ ___ ___ , ___ ___ ___

Check Number _____ CC _____