Membership Application

Contact Name: ____

Company: ____

Address: ____

City: ____ St: _____ Zip: _____

Phone: (_____)_________________________

Fax: (_____)___________________________

Email: _____________________________PSA: ____

Leg District: ____

I hereby make application for membership in the Illinois Assn of Community Care Program Homecare Providers, Inc. and, if accepted, will abide by its bylaws, support its objectives and pay its membership dues.

Signature: ________________________________ Date: ________________________________

Annual dues is based on the amount of CCP services delivered:

$ 500,000 and under	$ 225 annual dues
$ 500,001 to $1,000,000	$ 450 annual dues
$1,000,001 to $2,500,000	$ 875 annual dues
$2,500,001 to $4,000,000	$ 1,400 annual dues
$4,000,001 to $8,000,000	$ 2,200 annual dues
$8,000,001 to $15,000,000	$ 4,000 annual dues
$15,000,001 and over	$ 5,000 annual dues

Membership year is from July 1 to June 30. First year dues full payment, second year will be prorated.

Please make check payable to IACCPHP and mail to:
3085 Stevenson Drive, Suite 200
Springfield, IL 62703