



Illinois Association of
Community Care Program Homecare Providers
Membership Application

SEND COMPLETED APPLICATION TO:

Illinois Association of Community Care Program Homecare Providers • 100 E. Washington Street • Springfield, IL 62701
Phone: 217-528-3183 • Fax: 217-528-6545 • info@iaccpHP.org

Is this a new/first-time application? Yes No

STEP 1: PROFILE

CONTACT INFORMATION

Agency Name:

Address (for display on IACCPHP web directory):

City:

State:

Zip:

Phone:

Fax:

Agency Website:

Billing Address (if different than above):

City:

State:

Zip:

Phone:

Fax:

Executive Director/CEO Name:

Email:

Primary Contact and Title:

Email:

(Please see Step 6 to submit additional staff names and email addresses to be added to the IACCPHP member benefit electronic mailing list for the *Notebook* e-newsletter and materials on upcoming IACCPHP educational events.)

DID SOMEONE REFER YOU TO IACCPHP? If so, please indicate _____

SERVICES

In which PSAs do you provide services? _____

Which CCP services do you provide?

- In-Home
- Adult Day
- Emergency Home Response
- Medication Dispensing

Number of clients served annually in Illinois: _____

Number of home care aides employed in Illinois: _____

Total number of employees in Illinois: _____

OTHER SERVICES

Do you provide any of the following services/programs?

- Home Health
- Private Duty
- Other Medicaid waiver

If yes, which waiver program? _____

CHECK THE COUNTIES SERVED BY YOUR AGENCY

- | | | | | | |
|------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Adams | <input type="checkbox"/> Cumberland | <input type="checkbox"/> Hardin | <input type="checkbox"/> Lee | <input type="checkbox"/> Morgan | <input type="checkbox"/> Shelby |
| <input type="checkbox"/> Alexander | <input type="checkbox"/> DeKalb | <input type="checkbox"/> Henderson | <input type="checkbox"/> Livingston | <input type="checkbox"/> Moultrie | <input type="checkbox"/> Stark |
| <input type="checkbox"/> Bond | <input type="checkbox"/> DeWitt | <input type="checkbox"/> Henry | <input type="checkbox"/> Logan | <input type="checkbox"/> Ogle | <input type="checkbox"/> St. Clair |
| <input type="checkbox"/> Boone | <input type="checkbox"/> Douglas | <input type="checkbox"/> Iroquois | <input type="checkbox"/> Macon | <input type="checkbox"/> Peoria | <input type="checkbox"/> Stephenson |
| <input type="checkbox"/> Brown | <input type="checkbox"/> DuPage | <input type="checkbox"/> Jackson | <input type="checkbox"/> Macoupin | <input type="checkbox"/> Perry | <input type="checkbox"/> Tazewell |
| <input type="checkbox"/> Bureau | <input type="checkbox"/> Edgar | <input type="checkbox"/> Jasper | <input type="checkbox"/> Madison | <input type="checkbox"/> Piatt | <input type="checkbox"/> Union |
| <input type="checkbox"/> Calhoun | <input type="checkbox"/> Edwards | <input type="checkbox"/> Jefferson | <input type="checkbox"/> Marion | <input type="checkbox"/> Pike | <input type="checkbox"/> Vermilion |
| <input type="checkbox"/> Carroll | <input type="checkbox"/> Effingham | <input type="checkbox"/> Jersey | <input type="checkbox"/> Marshall | <input type="checkbox"/> Pope | <input type="checkbox"/> Wabash |
| <input type="checkbox"/> Cass | <input type="checkbox"/> Fayette | <input type="checkbox"/> Jo Daviess | <input type="checkbox"/> Mason | <input type="checkbox"/> Pulaski | <input type="checkbox"/> Warren |
| <input type="checkbox"/> Champaign | <input type="checkbox"/> Ford | <input type="checkbox"/> Johnson | <input type="checkbox"/> Massac | <input type="checkbox"/> Putnam | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Franklin | <input type="checkbox"/> Kane | <input type="checkbox"/> McDonough | <input type="checkbox"/> Randolph | <input type="checkbox"/> Wayne |
| <input type="checkbox"/> Clark | <input type="checkbox"/> Fulton | <input type="checkbox"/> Kankakee | <input type="checkbox"/> McHenry | <input type="checkbox"/> Richland | <input type="checkbox"/> White |
| <input type="checkbox"/> Clay | <input type="checkbox"/> Gallatin | <input type="checkbox"/> Kendall | <input type="checkbox"/> McLean | <input type="checkbox"/> Rock Island | <input type="checkbox"/> Whiteside |
| <input type="checkbox"/> Clinton | <input type="checkbox"/> Greene | <input type="checkbox"/> Knox | <input type="checkbox"/> Menard | <input type="checkbox"/> Saline | <input type="checkbox"/> Will |
| <input type="checkbox"/> Coles | <input type="checkbox"/> Grundy | <input type="checkbox"/> Lake | <input type="checkbox"/> Mercer | <input type="checkbox"/> Sangamon | <input type="checkbox"/> Williamson |
| <input type="checkbox"/> Cook | <input type="checkbox"/> Hamilton | <input type="checkbox"/> LaSalle | <input type="checkbox"/> Monroe | <input type="checkbox"/> Schuyler | <input type="checkbox"/> Winnebago |
| <input type="checkbox"/> Crawford | <input type="checkbox"/> Hancock | <input type="checkbox"/> Lawrence | <input type="checkbox"/> Montgomery | <input type="checkbox"/> Scott | <input type="checkbox"/> Woodford |

AFFILIATIONS

Does your organization belong to another trade/professional association? No Yes (if yes, please list):

LEGISLATIVE INFORMATION

Do you have a good relationship with any elected officials? No Yes If yes, please list:

Official Name	Office/Position

STEP 2: DUES WORKSHEET

(You are **required** to complete dues worksheet information)

Membership dues are based on hours/units and the DOLLAR EQUIVALENT billed during the prior fiscal year.

Entity Billed	Units/Hours Billed	Dollar Equivalent
IDoA		
MCO		
TOTAL DOLLARS:		

STEP 3: MEMBERSHIP LEVEL

Mark your dues selection based on your **TOTAL DOLLARS** from the previous table.

Tier	Hours/Units Dollars Equivalent	IACCPHP Membership Dues
1	\$500,000 and under	<input type="checkbox"/> \$337.50
2	\$500,001 - \$1,000,000	<input type="checkbox"/> \$675.00
3	\$1,000,001- \$2,500,000	<input type="checkbox"/> \$1,312.50
4	\$2,500,001- \$4,000,000	<input type="checkbox"/> \$2,100.00
5	\$4,000,001- \$8,000,000	<input type="checkbox"/> \$3,300.00
6	\$8,000,001 – \$15,000,000	<input type="checkbox"/> \$6,000.00
7	\$15,000,001 and over	<input type="checkbox"/> \$7,500.00

STEP 4: DUES PAYMENT

<p>PAYMENT AMOUNT:</p> <div style="border: 2px solid black; width: 150px; height: 50px; margin: 10px auto; text-align: center; font-size: 2em;">\$</div> <p>Pay by check or credit card.</p> <p>CHECKS SHOULD BE MADE PAYABLE TO: IACCPHP 100 East Washington Street Springfield, IL 62701</p> <p><input type="checkbox"/> Check # _____</p>	<p>COMPLETE FOR CREDIT CARD PAYMENT ONLY - Do not mail or email credit card information. Fax application with credit card to 217-528-6545 or call 217-528-3183 to provide credit card information over the phone.</p> <p><input type="checkbox"/> Visa <input type="checkbox"/> MasterCard</p>	
	Name of Card Holder	
	Card#	
	Exp. Date	Security Code
	Card Billing Address (If different from above)	Zip Code
	Signature	

STEP 5: POLICIES

- Membership in the Illinois Association of Community Care Program Home Care Providers (IACCPHP) is open to providers participating in the Illinois Department on Aging's Community Care Program.
- Membership benefits begin upon receipt of payment.
- Membership renewals are subject to audit by IACCPHP. By submitting your dues renewal form, you agree to submit proof of revenue upon request.
- Membership dues are non-refundable.
- Dues payments to IACCPHP are not deductible as a charitable contribution for federal income tax purposes. Dues payments may be deductible as a business expense, less 4% of the dues payment utilized for IACCPHP's lobbying activities on behalf of members.
- All members must abide by the IACCPHP Code of Ethics.

I have read and understand the IACCPHP dues policies and certify that I have accurately estimated my revenue for the previous year and have calculated my dues correctly. I understand that membership applications/renewals are subject to audit by IACCPHP; I agree to submit proof of revenue upon request.

Signature _____

Title _____

Date _____

STEP 6: ADDITIONS TO MAILING LIST

Please list all additional staff to be added to the IACCPHP member benefit electronic mailing list to receive the *Notebook*, e-newsletter and receive materials on upcoming IACCPHP educational events.

Name: _____
Title: _____
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