

Step One: Company Information

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

Provider/Company Name: _____

Mailing Address: _____

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

Phone: (_____) _____ **Fax:** (_____) _____

Toll Free Phone: (_____) _____ **Individual E-Mail:** _____

Company E-Mail: _____ **Website:** _____

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

This organization is (Please check all that apply): Home Health Hospice Personal Services

Select Type (Please check ONE only): Medicare Certified Licensed HH Only (no Medicare) Certified – Medicaid Only Not Licensed Will Apply for Personal Care License

Please check what service lines you provide:

<input type="checkbox"/> Attendant Care	<input type="checkbox"/> Cardiac Care	<input type="checkbox"/> Companion Care	<input type="checkbox"/> Diabetic Care
<input type="checkbox"/> Home Health Aide	<input type="checkbox"/> Home Maker	<input type="checkbox"/> Home Medical Equipment	<input type="checkbox"/> Hospice
<input type="checkbox"/> Infusion Therapy	<input type="checkbox"/> Maternal/Child	<input type="checkbox"/> Medical Adult Day Care	<input type="checkbox"/> Medical Social Worker
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Respiratory Care
<input type="checkbox"/> Respite Care	<input type="checkbox"/> Sitter	<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Wound Care Management	<input type="checkbox"/> Other		

Please check all the counties your agency serves:

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

Step Two: Additional Locations

If you have additional locations and would like them to receive IAHC mailings, please provide addresses for each office or branch whose revenues are included in your membership dues. Please fill out the information below. If you have more than two please duplicate.

1. **Contact Person** (Person designated to receive mailings): _____

Mailing Address: _____

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

Phone: (_____) _____ **Fax:** (_____) _____

E-Mail Address: _____

Counties Served: _____

2. **Contact Person** (Person designated to receive mailings): _____

Mailing Address: _____

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

Phone: (_____) _____ **Fax:** (_____) _____

E-Mail Address: _____

Counties Served: _____

***NOTE:** If certain locations serve specific counties you may duplicate this page and complete the services/counties information for each location/branch. This does not affect your dues total- But is very important for your profile to be listed correctly on our website directory.

Step Three: Dues Schedule

The 2006 IAHC dues shall be based on the sum of all 2005 projected Indiana in-home services gross revenue less contractual; from entities under common ownership, control or board direction. Include revenue of all agencies that you have acquired or merged with in the last year. **If complete fiscal year data is not available, please use most recent year-end result or project revenue to the end of the year.** Thus, the dues calculation is applied to: **gross revenues less contractual adjustments, revenues generated from Indiana business, all Indiana business for entities under common ownership, control or board direction, and revenues generated from:**

- ✓ Home Health Services
- ✓ Hospice
- ✓ Personal Care/Attendant Services
- ✓ Companion/Sitter Services
- ✓ Extended Care Services
- ✓ Therapy Services

For new start-up agencies and agencies that have not been members in the past, an introductory membership fee will give everyone the opportunity to join IAHC for only \$500 for the first membership year, which is based on the calendar year. "New" members exclude those agencies that were members in 2003, 2004, or 2005 and have been acquired or combined under a new organization. If you have acquired or merged with another provider, be sure to count the revenues of all entities combined in 2005. For established or previous members – IAHC now provides one mailing of the **Communiqué** to each office or additional location whose revenues you include in your dues. There will be no additional charge for these "extra mailings". The electronic version of the **Communiqué** can be delivered to as many of your staff as you request.

2005 Revenue Less Contractuals	2006 Dues if Paid in Full by January 31 st	2006 Dues if Paid In Installments or Received After January 31 st
Introductory Rate	\$ 500	\$ 500
\$1 - \$250,000	\$ 600	\$ 635
\$250,001 - \$500,000	\$ 750	\$ 825
\$500,001 - \$1,500,000	\$ 1,250	\$ 1,380
\$1,500,001 - \$2,500,000	\$ 2,500	\$ 2,800
\$2,500,001 - \$3,500,000	\$ 3,750	\$ 4,200
\$3,500,001 - \$4,500,000	\$ 5,000	\$ 5,500
\$4,500,001 - \$5,500,000	\$ 6,250	\$ 6,900
\$5,500,001 - \$7,500,000	\$ 7,500	\$ 8,300
\$7,500,001 - \$10,000,000	\$ 8,200	\$ 9,000
\$10,000,001 - \$12,500,000	\$ 9,000	\$ 9,900
\$12,500,000- \$15,000,000	\$ 9,500	\$10,500
\$15,000,001 & Up	\$10,000	\$11,000

Note: Contributions to IAHC are not deductible as charitable contributions for federal income tax purposes. However, 85% 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. For IAHC members, this means that the portion of dues directed to lobbying expenses is not deductible by the member/taxpayer. For 2006, we estimate this to be 15% of your dues payment.

Step Four: Electronic version of the Communiqué

Your company can now receive the **Communiqué** electronically and save time and money! The electronic version of the **Communiqué** can be delivered to as many of your staff as you request. Please fill in the name and email address of the person who would like to receive the **Communiqué** via email. If you need additional space please send on a separate sheet.

Name _____ E-Mail _____
 Name _____ E-Mail _____
 Name _____ E-Mail _____

Step Five: Sign and Submit Application with Payment

A. Signature Required

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 IAHC 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 (IAHC).

 Administrator or Contact Person

 Date

B. Payment Information

- Full payment enclosed of 2006 Membership Dues from Step Three (if paid in full by 1/31/06) \$_____.
- Please enroll me in the 2006 Membership Dues convenient payment plan. I will pay 3 equal installments of \$_____ due January 31st, March 31st & May 31st totaling \$_____.
- I would like to make a contribution to the IAHC Political Action Committee of \$_____.

TOTAL AMOUNT ENCLOSED \$_____

Please make checks payable to:
IAHC
 8604 Allisonville Road, Suite 260
 Indianapolis, IN 46250
 Phone: (317) 844-6630
FAX: (317) 575-8751

For office use ONLY

Date Paid _____
 Check Check Number _____
 Credit Card Authorization Number _____
 Cash