

Step One: Company Information/Main Location

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

<input type="checkbox"/> Home Health	<input type="checkbox"/> Hospice	<input type="checkbox"/> Personal Services (Non-medical)	<input type="checkbox"/> Business Office Only (No services from this office)
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Type of Agency: (Please check ONE only)

<input type="checkbox"/> Certified - Home Health	<input type="checkbox"/> Certified - Hospice	<input type="checkbox"/> Certified - Medicaid Only
<input type="checkbox"/> Licensed Home Health Only	<input type="checkbox"/> Licensed PSA Only	<input type="checkbox"/> Not Licensed - Will Apply

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

Please check the counties that this location serves:

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

Please check the services that this location provides:

<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"/> Other	<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
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Step Two: Additional Locations (See Page 3 - optional)

Please use the attached sheet to identify all additional locations whose revenues are included in your membership dues. Please fill in the information completely to ensure accurate information will be put into the database which consumers use to find a provider in their area. Please photocopy this page, if needed.

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 IAHC, including the electronic version of the Communiqué. This will also make on-line registration easier as your employees will already be in the system.

Continued on next page

For Office Use ONLY

Welcome Packet Sent ____ / ____ / 20__

Paid in Full / First Installment	Second Installment	Third Installment
Date Paid ____ / ____ / 20__	Date Paid ____ / ____ / 20__	Date Paid ____ / ____ / 20__
Amount Paid \$ _____	Amount Paid \$ _____	Amount Paid \$ _____
Check Number _____	Check Number _____	Check Number _____
CC Authorization _____	CC Authorization _____	CC Authorization _____
Profile Update: What? _____	Date: ____ / ____ / 20__	By: _____
Profile Update: What? _____	Date: ____ / ____ / 20__	By: _____
Profile Update: What? _____	Date: ____ / ____ / 20__	By: _____

The 2010 IAHC dues shall be based on the sum of all 2009 projected Indiana in-home services collected revenue; 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: **collected revenues generated from all Indiana business for entities under common ownership, control or board direction, generated from:**

- ✓ Home Health Services
- ✓ Companion/Sitter Services
- ✓ Hospice
- ✓ Extended Care Services
- ✓ Personal Care/Attendant 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 \$700 for the first membership year, which is one year from the month you join. "New" members exclude those agencies that were members in 2007, 2008, or 2009 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 2009. IAHC provides one mailing of the **Communiqué** to each office or additional location whose revenues you include in your dues. The electronic version of the **Communiqué** can be delivered to as many of your staff as you request.

2009 Revenue Less Contractuals	2010 Dues Single Payment	2010 Dues 3 Payments	
		Total	Each Payment
Introductory Rate	\$ 700	Not Available	
\$1 - \$250,000	\$ 700	\$ 795	\$ 265
\$250,001 - \$500,000	\$ 860	\$ 990	\$ 330
\$500,001 - \$1,500,000	\$ 1,440	\$ 1,650	\$ 550
\$1,500,001 - \$2,500,000	\$ 2,880	\$ 3,300	\$ 1,100
\$2,500,001 - \$3,500,000	\$ 4,270	\$ 4,950	\$ 1,650
\$3,500,001 - \$4,500,000	\$ 5,650	\$ 6,450	\$ 2,150
\$4,500,001 - \$5,500,000	\$ 7,025	\$ 8,100	\$ 2,700
\$5,500,001 - \$7,500,000	\$ 8,350	\$ 9,600	\$ 3,200
\$7,500,001 - \$10,000,000	\$ 9,275	\$10,650	\$ 3,550
\$10,000,001 & Up	\$ 10,000	\$11,400	\$ 3,800

IAHC membership extends one year from the month you join the Association.

Note: Contributions to IAHC 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. For IAHC members, this means that the portion of dues directed to lobbying expenses is not deductible by the member/taxpayer. For 2010, we estimate this to be 12% of your dues payment.

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

- Enclosed is payment in full in the amount of 2010 Membership Dues based on Step Four above \$_____.
- Please enroll me in the 2010 Membership Dues convenient payment plan. My first payment is due today. My **second payment** is due two months from today on _____ and my **final payment** is due four months from today on _____.
I will pay 3 equal payments of \$_____ for a total of \$_____.
- I would like to make a contribution to the **Hoosiers Helping Home & Hospice Care PAC** for Political Action & Public Education of \$_____.

I plan to pay by:

- Check (Made payable to IAHC)
- Credit Card: Visa MasterCard

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: ____ / ____ Security Code: _____

Please make checks payable to:
IAHC
PO Box 623248
Indianapolis, IN 46262-3248
Phone: (317) 844-6630
FAX: (317) 575-8751
Register On-line: www.iahhc.org

Payment Summary:	
Membership Dues, Single Payment	\$ _____
Membership Dues, First Payment	\$ _____
PAC Contribution (optional)	\$ <u>100</u>
Total Amount Enclosed	\$ _____