

### 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 Info Email:** \_\_\_\_\_

**Fax:** (\_\_\_\_\_) \_\_\_\_\_ **Individual Work Email:** \_\_\_\_\_

**Toll Free Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Website:** \_\_\_\_\_

**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

Number of Employees: FT: \_\_\_\_\_ PT/PRN: \_\_\_\_\_

Ownership:  Public  Private Non-Profit  Private For-Profit  Hospital-Based/Public  
 Hospital-Based/ Private Non-Profit  Hospital-Based/ Private For-Profit

Is your Home Health Agency Medicare-Certified?  Yes  No  Not Applicable

Do you provide Hospice Services?  Yes  No  Not Applicable

Do you operate a Hospice Residential Facility?  Yes  No

If yes, name and location of facility: \_\_\_\_\_

Is your Hospice Agency Medicare-Certified?  Yes  No  Not Applicable

Do you provide Home Health Services?  Yes  No  Not Applicable

Is Your Agency Accredited?  Yes  No

If yes, by whom? : \_\_\_\_\_

Is Your Agency a Provider of Medicaid Waiver?  Yes  No

Is Your Agency a Provider of Personal Services?  Yes  No

If yes, do you have a separate license for those services?  Yes  No

Is Your Agency a Member of NAHC?  Yes  No

Is Your Agency a Member of NHPCO?  Yes  No

Is Your Agency a Member of Home Care Association of America?  Yes  No

Is Your Agency a Member of IHPCO?  Yes  No

Is Your Agency a Member of Indiana Health Care Association?  Yes  No

Is Your Agency a Member LeadingAge?  Yes  No

Is Your Agency a Member of Hoosier Owners and Providers for the Elderly?  Yes  No

What can IAHC do to make your membership more valuable?

Note: You may also email your comments to IAHC Executive Director Evan Reinhardt at [evan@iahhc.org](mailto:evan@iahhc.org).

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

Please check the counties that this location serves:

Any updates since previous membership?  Yes  No

- Grid of 80 county names with checkboxes: Adams, Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, Dearborn, Decatur, DeKalb, Delaware, Dubois, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, LaGrange, Lawrence, Lake, LaPorte, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Shelby, Spencer, Starke, St. Joseph, Steuben, Sullivan, Switzerland, Tipton, Union, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, Whitley

Please check the services that this location provides:

Any updates since previous membership?  Yes  No

- Grid of 16 service categories with checkboxes: Attendant Care, Cardiac Care, Companion Care, Diabetic Care, Home Health Aide, Home Medical Equipment, Hospice, Infusion Therapy, Maternal/Child, Medical Social Worker, Palliative Care, Pediatrics, PERS, Physical Therapy, Respiratory Care, Sitter, Skilled Nursing, Speech Therapy, Telehealth, Wound Care Management

Step Two: Additional Locations (See Page 4)

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

Step Three: Additional Staff (See Page 5)

Please use the attached sheet to identify additional staff that you would like to receive correspondence from IAHC. 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 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

2020 Revenue Less Contractuals	2021 Dues
New Member Rate**	\$ 795
\$1 - \$250,000	\$ 810
\$250,001 - \$500,000	\$ 995
\$500,001 - \$1,500,000	\$ 1,670
\$1,500,001 - \$2,500,000	\$ 3,330
\$2,500,001 - \$3,500,000	\$ 4,944
\$3,500,001 - \$4,500,000	\$ 6,544
\$4,500,001 - \$5,500,000	\$ 8,140
\$5,500,001 - \$7,500,000	\$ 9,680
\$7,500,001 - \$8,500,000	\$10,245
\$8,500,001 - \$10,000,000	\$10,770
\$10,000,001 - \$11,000,000	\$11,365
\$11,000,001 & Up	\$11,730
<b>Membership extends one year from the month you join.</b>	

Your IAHC dues are based on your previous 12 months collected revenue generated from all services including home health services, hospice, palliative care, personal care/attendant care services from providers who are located at the address listed under Main Location. For example, if ABC home care provides home health and hospice services from the same office, the dues will be based on the combined revenue for the home health and hospice services. If XYZ agency has separate provider numbers for offices at different locations, then each separately located agency must join IAHC with its own membership.

**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. This means that the portion of dues directed to lobbying expenses is not deductible by the member/taxpayer. For 2021, 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](http://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 IAHC members in the past. "New" members exclude those agencies that were members in 2018, 2019 or 2020 and have been acquired or combined under a new organization.

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

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

**Provider/Company Name:** \_\_\_\_\_

**2021 Membership Dues Level:** \$ \_\_\_\_\_

**I affirm by my signature that the revenue level reported on this application is accurate.**

\_\_\_\_\_  
Signature of CEO

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of CFO

\_\_\_\_\_  
Date

**Method of Payment**

- Check (Made payable to IAHC)     Visa     MasterCard     American Express

Credit Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_                      Security Code: \_\_\_\_\_

Card Holder's Name (please print legibly): \_\_\_\_\_

Card Holder's Billing Address \_\_\_\_\_

**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:** IAHC  
 6320 – G Rucker Road  
 Indianapolis, IN 46220  
**Fax:** (317) 775-6674  
**Register Online:** [www.iahhc.org](http://www.iahhc.org)

**Payment Summary:**

**Amount Due:** \$ \_\_\_\_\_

**PAC Contribution (optional)** \$ \_\_\_\_\_

**Total Amount Enclosed:** \$ \_\_\_\_\_

**For IAHC Use Only**

Date Paid \_\_\_\_ / \_\_\_\_ / 20 \_\_\_\_

Amount Paid \$ \_\_\_\_\_ , \_\_\_\_\_

Check Number \_\_\_\_\_ CC \_\_\_\_\_

### Step Two: Company Information for Additional Location

*Please note: If this location has a separate provider or license number, it is not eligible to be an additional location. The location must join IAHHC with its own membership.*

**Provider/Company Name:** \_\_\_\_\_

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

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Company Info Email:** \_\_\_\_\_

**Fax:** (\_\_\_\_\_) \_\_\_\_\_ **Individual Work Email:** \_\_\_\_\_

**Toll Free Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Website:** \_\_\_\_\_

**Number of Employees:** FT: \_\_\_\_\_ PT/PRN: \_\_\_\_\_

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

<input type="checkbox"/> Home Health	<b>Select Type</b>	<input type="checkbox"/> Certified - Home Health	<input type="checkbox"/> Licensed Home Health Only
<input type="checkbox"/> Hospice	(Please check ONE only):	<input type="checkbox"/> Certified - Hospice	<input type="checkbox"/> Licensed PSA Only
<input type="checkbox"/> Personal Services (Non-medical)		<input type="checkbox"/> Certified - Medicaid Only	<input type="checkbox"/> Not Licensed - Will Apply
<input type="checkbox"/> Business Office Only (No services from this office)			

**This location accepts** (Please check all that apply):  CHOICE  Commercial  Medicaid  Medicare  Private Pay  VA  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"/> Home Medical Equipment	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Skilled Nursing
<input type="checkbox"/> Cardiac Care	<input type="checkbox"/> Hospice	<input type="checkbox"/> PERS	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Companion Care	<input type="checkbox"/> Infusion Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Telehealth
<input type="checkbox"/> Diabetic Care	<input type="checkbox"/> Maternal/Child	<input type="checkbox"/> Respiratory Care	<input type="checkbox"/> Wound Care Management
<input type="checkbox"/> Home Health Aide	<input type="checkbox"/> Medical Social Worker	<input type="checkbox"/> Respite Care	<input type="checkbox"/> Other _____
<input type="checkbox"/> Home Maker	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Sitter	

**Please photocopy for each additional location.**

### For Office Use Only

Parent Company: \_\_\_\_\_

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**Step Three: Additional Staff**

Please list any additional staff 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. You **MUST** include individual email addresses for each person. *If you have more than one location, please indicate the office to which the person is assigned.*

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Additional Staff Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Office Location:** \_\_\_\_\_

**Please photocopy for any additional staff.**

In order to keep our database up-to-date, please update staff profiles as information changes. Thank you.