

## Step One: Company Information/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: \_\_\_\_\_

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

 This location offers  Personal Services  
 this service: (Non-medical) **Type of Agency:**  Licensed PSA Only  Not Licensed - Will Apply

(Please check ONE only)

 This organization accepts (Please check all that apply):  CHOICE  Credit Cards  LTC Insurance  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	

 Services provided:  Attendant Care  Companion Care  Home Maker  Personal Emergency Response System (PERS)  
 Respite Care  Sitter  Other \_\_\_\_\_

## Step Two: Additional Locations (See Page 3)

Please use the attached sheet to identify all additional locations under your license number. If a location has its own license number, it does not qualify to be an additional location and must join as a Voting member.

## Step Three: Additional Staff (See Page 4)

Please use the attached sheet to identify additional staff that 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.

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 IAHHC 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 (IAHHC).

Administrator or Contact Person

Date

## Step Four: Calculate Your Dues

2025 Revenue Less Contractuals	2026 Dues
New Member Rate**	\$647
\$1 - \$250,000	\$ 657
\$250,001 - \$500,000	\$843
\$500,001 - \$1,500,000	\$1,420
\$1,500,001 - \$2,500,000	\$2,909
\$2,500,001 - \$3,500,000	\$4,779
\$3,500,001 - \$4,500,000	\$6,331
\$4,500,001 - \$5,500,000	\$8,783
\$5,500,001 - \$7,500,000	\$10,465
\$7,500,001 - \$8,500,000	\$11,626
\$8,500,001 - \$10,000,000	\$12,215
\$10,000,001 - \$11,000,000	\$12,918
\$11,000,000 & Up	\$13,335
<b>Membership extends one year from the month you join.</b>	

Your IAHHC dues will be based on your previous 12 months collected revenue generated from your license number.

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) to view organization information and then select membership information on the info hub.

**Note:** Contributions to IAHHC 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 2026, we estimate this to be 12% of your dues payment.

\*\*The new member rate is available only for new start-up agencies that have not been billing/in the market. "New" members exclude those agencies that have been acquired or combined under a new organization.

Installment payment plans are available; eligibility will be determined by IAHHC at time of need. Contact IAHHC's Membership Director at 317-734-3887 for more information. New members are not eligible for installment plans.

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

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

2026 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 \_\_\_\_\_

Check (Made payable to IAHHC)  Visa  MasterCard  American Express

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

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

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

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

As a member of IAHHC, your staff can now receive unlimited online homecare specific courses through RCTCLEARN.NET. The RCTC program offers you convenience because the courses can be taken anytime, anywhere.

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:** IAHHC  
6320 - G Rucker Road  
Indianapolis, IN 46220  
**Fax:** (317) 775-6674

**Online:** Please email [michelle@iahhc.org](mailto:michelle@iahhc.org) so that an invoice may be created

**Payment Summary:**

**Dues Amount:** \$ \_\_\_\_\_  
**PAC Contribution (optional)** \$ \_\_\_\_\_  
**Total Amount Enclosed:** \$ \_\_\_\_\_

## For IAHHC Use Only

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

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

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

**Step Two: Company Information for Additional Location**

*Please note: If this location has its own license, it is not eligible as 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 this service:**  Personal Services (Non-medical) **Type of Agency:**  Licensed PSA Only (Please check ONE only)  Not Licensed - Will Apply

**This organization accepts** (Please check all that apply):  CHOICE  Credit Cards  LTC Insurance  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
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**Services provided:**  Attendant Care  Companion Care  Home Maker  Personal Emergency Response System (PERS)  
 Respite Care  Sitter  Other \_\_\_\_\_

**Please photocopy for each additional location.**

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**For Office Use Only**

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

### 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:** \_\_\_\_\_

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

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

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**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.