

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 IAHHC do to make your membership more valuable?

Note: You may also email your comments to IAHHC Executive Director Evan Reinhardt at 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 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

2024 Revenue Less Contractuals	2025 Dues
New Member Rate**	\$ 876
\$1 - \$250,000	\$893
\$250,001 - \$500,000	\$,1098
\$500,001 - \$1,500,000	\$1,845
\$1,500,001 - \$2,500,000	\$3,674
\$2,500,001 - \$3,500,000	\$5,457
\$3,500,001 - \$4,500,000	\$7,222
\$4,500,001 - \$5,500,000	\$8,980
\$5,500,001 - \$7,500,000	\$10,685
\$7,500,001 - \$8,500,000	\$11,308
\$8,500,001 - \$10,000,000	\$11,887
\$10,000,001 - \$11,000,000	\$12,542
\$11,000,001 & Up	\$12,947
Membership extends one year from the month you join.	

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 2025, we estimate this to be 12% of your dues payment.

*To view your previous year's dues, the primary contact may log in to www.iahc.org to access organization information and then select the membership information on the info hub.

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

Installment payment plans are available; eligibility will be determined by IAHC at time of need. Contact IAHC's Membership Director at (317) 775-6672 for more information. New

Step Five: Payment Information (Payment MUST accompany application)

Provider/Company Name: _____

2025 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
Online: Please send email to michelle@iahc.org
 So invoice may be created for online payment

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	Select Type	<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: _____

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: _____

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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.