Indiana Association for Home & Hospice Care

2025 Voting Membership Application - Home Health & Hospice

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.

Step One: Company Information for Main Location

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

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

Please check the services that this location provides:
Any updates since previous membership? ❑ Yes ❑ No

❑ Attendant Care	❑ Home Medical Equipment	❑ Palliative Care	❑ Sitter
❑ Cardiac Care	❑ Hospice	❑ Pediatrics	❑ Skilled Nursing
❑ Companion Care	❑ Infusion Therapy	❑ PERS	❑ Speech Therapy
❑ Diabetic Care	❑ Maternal/Child	❑ Physical Therapy	❑ Telehealth
❑ Home Health Aide	❑ Medical Social Worker	❑ Respiratory Care	❑ 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 _____

Step Four: Calculate Your Dues

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 IAHHC 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 IAHHC with its own membership.

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. For2025, 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.iahhc.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 IAHHC at time of need. Contact IAHHC's Membership Director at 317-734-3887 for more information.

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 IAHHC) ☐ 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: IAHHC
6320 – G Rucker Road
Indianapolis, IN 46220

Fax: (317) 775-6674

Online: Please send email to leslie@iahhc.org
So invoice may be created for online payment

Payment Summary:

Amount Due: **$**_____

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 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)*
- ❑ Home Health
- ❑ Hospice
- ❑ Personal Services (Non-medical)
- ❑ Business Office Only (No services from this office)

Select Type *(Please check ONE only)*:
- ❑ Certified - Home Health
- ❑ Certified - Hospice
- ❑ Certified - Medicaid Only
- ❑ Licensed Home Health Only
- ❑ Licensed PSA Only
- ❑ Not Licensed - Will Apply

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

Please check the counties that <u>this location</u> serves:

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

Please check the services that this location provides:

❑ Attendant Care	❑ Home Medical Equipment	❑ Pediatrics	❑ Skilled Nursing
❑ Cardiac Care	❑ Hospice	❑ PERS	❑ Speech Therapy
❑ Companion Care	❑ Infusion Therapy	❑ Physical Therapy	❑ Telehealth
❑ Diabetic Care	❑ Maternal/Child	❑ Respiratory Care	❑ Wound Care Management
❑ Home Health Aide	❑ Medical Social Worker	❑ Respite Care	❑ Other _____
❑ Home Maker	❑ Occupational Therapy	❑ 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:** ______________

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Job Title: ______________ **Office Location:** ______________

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Job Title: ______________ **Office Location:** ______________

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Job Title: ______________ **Office Location:** ______________

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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.