

IHCA Membership Application

(please type or print clearly)

Important

(Fill in appropriate blanks with number of beds)

TOTAL Licensed beds/slots _____
 Skilled _____ CILA _____
 ICF _____ CRA _____
 Sheltered _____ ICF/DD _____
 Assisted Living _____
 ICF/MI _____
 Skilled Pediatric _____
 Total MEDICARE Certified Beds _____
 Total MEDICAID Certified Beds _____

Philosophy and Code of Ethics of the Illinois Health Care Association

- * A basic human right is to have accessible quality health care.
- * Full members will provide care that will meet the physiological, psychological, environmental, and spiritual needs of each resident in licensed or certified facilities or programs.
- * Full members will provide qualified staff in sufficient numbers to perform competent services to meet residents' needs.
- * Members will be fair and honest in all their transactions.
- * Members are encouraged to engage in research and education, which will be done with the assurance that the interest and dignity of each individual is preserved and the conduct of the program is of professional quality.
- * Members are encouraged to attend and participate in all appropriate Association meetings and activities.
- * Members will clearly delineate their policies and will receive and act upon complaints and suggestions, utilizing established procedures of the state and national associations and related community resources.
- * Members will be an integral part of the community's health program.

Facility/Program Name _____ House District # _____

Facility/Program Address _____ Senate District # _____

City _____ Congressional District # _____

State _____ ZIP _____ County _____

Phone (_____) _____ Fax (_____) _____

E-mail _____ Website _____

H.S.A/Geographical Area _____ Public Health Region _____

Administrator's Name _____ Fed. Medicare Provider # _____

Business Structure Individual Partnership Corporation

For Profit Status Proprietary-For Profit Non-Proprietary-Not-For-Profit County

If Corporation:

Name _____

Address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____

E-mail _____

Owner(s)/Principal Shareholders:

Name _____ Phone (_____) _____

Address _____

Name _____ Phone (_____) _____

Address _____

Most recent license issue date to facility/program _____ No. of years licensed _____

Has license ever been revoked, refused, or suspended? Yes No

Was facility previously a member of IHCA? Yes No If yes, when? _____

Previous Name _____

Age of Facility _____ Life Safety Code (LSC) _____ year

Facility Application

Please be advised that, per section 6033(e) of the Internal Revenue Code, Illinois Health Care Association reasonably estimates that 37.23% of your dues will be spent on lobbying and other expenditures subject to section 162(e) (1) of the Code and therefore is not deductible for federal income tax purposes.

This applies to For-Profit facilities only. Up to 33% of your dues will be allocated for Political Action purposes based on action taken by the IHCA Board of Directors on December 20, 2007. Therefore this is not deductible for Federal Income Tax purposes.

Undersigned agrees that the Illinois Health Care Association, Illinois Health Care Association PAC (IHCA-PAC), The Center for Developmental Disability Advocacy and Community Supports, the Long Term Care Nurses Association (LTCNA), and the John W. Maitland, Jr./Joseph F. Warner Long Term Care Nurses Scholarship Fund may send fax and e-mail to the numbers/addresses indicated on this application.

I represent that if I am not the owner or licensee of the facility or program for which application for membership is made, I have the authority to, and by signing this application, intend to legally bind the facility or program. I hereby agree to pay dues assessed by the Illinois Health Care Association and further agree to uphold the Code of Ethics of said Association. If membership is canceled, the Association must be given 30 day advance written notification. I further agree that if the Association takes legal action to collect unpaid dues, venue will be in Sangamon County, Illinois, and I will pay the costs of collection incurred by the Association including reasonable attorneys' fees.

Signature _____ Date _____

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(Revised 1/2012)

FOR ASSOCIATION USE

Fee _____ Check # _____

Date Rec'd _____

Region # _____ Facility ID# _____

Independent Owner

Multi-Facility

Hospital-Based _____

Full Member Facility/Program Profile

IHCA Dues

GERIATRIC, DD, CILA, AND CRA

Dues are \$4.60 per licensed bed or program slot per month. The minimum monthly dues rate is \$46 and the maximum is \$1,012.

Note: Dues are considered an allowable cost under the current IDPA reimbursement system.

SHELTERED CARE

Dues for 100% Sheltered Care are based on licensed beds at \$2.40 per bed per month.

ASSISTED LIVING

Dues for 100% Assisted Living are based on licensed beds at \$2.40 per bed per month.

Support Services

(Please check services which you provide to your residents or the community)

- | | |
|---|--|
| <input type="checkbox"/> Alzheimer's Unit | <input type="checkbox"/> Outpatient Health Care Clinic |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Other Service (e.g., electronic emergency response, financial services, health education, etc.) |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Recreational Activities |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Counseling/Psychiatric Care | <input type="checkbox"/> Rehabilitation Services (e.g., occupational, physical and/or speech/hearing therapy) |
| <input type="checkbox"/> Congregate Meals | <input type="checkbox"/> Religious Services |
| <input type="checkbox"/> Day Care (Adult) | <input type="checkbox"/> Retirement Apartments |
| <input type="checkbox"/> Day Training | <input type="checkbox"/> Senior Care |
| <input type="checkbox"/> Exceptional Medical Care (DPA) | <input type="checkbox"/> Sub-Acute Care |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Transportation/Escort |
| <input type="checkbox"/> Homemaker/Chore Services | <input type="checkbox"/> Ventilator or other special care units |
| <input type="checkbox"/> Hospice Care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Information and Referral | (please specify) |
| <input type="checkbox"/> Meals on Wheels | |

Special Characteristics

(Please check all that apply)

- JCAHO - Accredited Home
- Certificate of Need Pending or Being Developed
- Part of a Multi-Facility Corporation — Number of facilities or programs in the corporation: _____
- CARF - Accredited Program
- Other _____ (please specify)

IHCA Member Services

In order of importance, which of the following IHCA services are of greatest interest to you as a new member? Rank 1-5, with 1 being the most important.

- _____ Convention and Trade Show
- _____ Educational Seminars
- _____ Legislative Efforts
- _____ Member Benefit Services
- ATD Employer Solutions (ancillary employee benefits)
 - CareWatch (MDS data management system)
 - HealthCare Associates Credit Union
 - M.E.S./HPSI (group purchasing)
 - Nursing Resources International (Foreign Nurse Recruiting Program)
 - SilverChair Learning (online staff education services)
 - Verify (employee background checks)
- _____ Electronic Newsletters/Publications
- _____ Other (e.g., regional meetings, standing committee participation, telephone access to staff, etc.)
- Please explain
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