IHCA
ILLINOIS HEALTH CARE ASSOCIATION®
SINCE 1950

ICAL
ILLINOIS CENTER FOR ASSISTED LIVING

Membership Application | 2024

(please type or print clearly)

Facility/Program Name _____ House District #_____

Facility/Program Address _____ Senate District # _____

City _____ Congressional District # _____

State _____ Zip _____ County _____

Phone ( ) _____ Fax ( ) _____

Email _____ Website _____

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

Administrator's Name _____

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 ( ) _____

Email _____

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Has license ever been revoked, refused, or suspended?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 _____

Facility Application

Please be advised that, per section 6033(e) of the Internal Revenue Code, Illinois Health Care Association reasonably estimates that 35.08% of your 2024 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.

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 email 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 Assocation. 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**

Important

(Fill in appropriate blanks with number of beds)

TOTAL Licensed beds/slots_____

Skilled _____

ICF _____

Sheltered _____

AL_____ SLF _____

SMHRF _____

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.

FOR ASSOCIATION USE

Fee_____Check #_____

Date Rec'd _____

Region #_____ Facility ID# _____

❑ Independent Owner

❑ Multi-Facility

❑ Hospital-Based

Illinois Health Care Association | 1029 South Fourth Street | Springfield, IL 62703-2224
800-252-8988 | 217-528-6455 | Fax 217-528-0452 | www.ihca.com | info@ihca.com

(Rev 1/2024)

IHCA
Illinois Health Care Association®
Since 1950

ICAL
Illinois Center for Assisted Living

IHCA Dues

GERIATRIC DUES are $7.00 per licensed bed per month.
ID/DD, MC/DD AND CILA DUES are $6.45 per licensed bed or program slot per month. The minimum monthly dues rate is $50
Note: Dues are considered an allowable cost under the current reimbursement system.

SHELTERED CARE
Dues for 100% Sheltered Care are based on licensed beds at $2.85 per bed per month.

ASSISTED LIVING & SUPPORTIVE LIVING
Dues for 100% Assisted Living are based on licensed beds at $2.85 per bed per month.

Full Member Facility/Program Profile

IHCA Communications (How To Receive IHCA Newsletters)

In order to receive IHCA's electronic publications, an individual must have their own unique log in credentials. IHCA members can let us know which newsletters they would like to receive by logging into the member portal and updating their communications preferences in their contact profile. The Administrator/Contact listed on this form will be listed as the Primary Contact for your organization. Once the company information has been entered into our membership database, the Primary Contact will be able to log in and create new contacts under your organization. To find out how to create additional contact profiles, please log into the member portal and go to the **Members Only page. There you will find helpful instructions and other documents.**

Support Services

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

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

(please specify)

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 Expo
_____ Educational Seminars
_____ Legislative Efforts
_____ Member Benefit Services
- — Accurate Biometrics (fingerprinting services)
- — CE Solutions (online staff education services)
- — HPSI (group purchasing)
- — NRC Health (performance measurement/improvement)
- — Prescription Cost Management (prescription cost savings using current pharmacy providers)

_____ Electronic Newsletters/Publications
_____ Other (e.g., regional meetings, standing committee participation, telephone access to staff, etc.)
Please explain _____