



APPLICATION MUST BE COMPLETED TO BE CONSIDERED FOR MEMBERSHIP.

I. COMPANY INFORMATION

New Member Renewing Member

Agency Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone Number: _____ Fax: _____ Email: _____

Website: _____

Do you have other locations? Yes No *If yes, please provide (page 4) to CAHSAH at membership@cahsah.org.*

Has your agency or any other agency with which you have been affiliated ever had their CAHSAH Home Care Aide Organization Certification or CAHSAH membership revoked or denied? Yes No *If yes, please explain:* _____

II. STAFF INFORMATION

Please add a Key Contact, Voting Delegate (if different than the Key Contact) and additional staff members who will receive CAHSAH information (i.e. CEO, COO, ExecMgr, etc). If you would like to add more, please call Membership at (916) 641-5795 or e-mail: membership@cahsah.org.

Key Contact *(receives all CAHSAH publications via email)*

Name: _____

Title/Degree: _____

Email: _____

Voter Delegate *(if different from Key Contact)*

Name: _____

Title/Degree: _____

Email: _____

Additional Personnel to receive CAHSAH Email Publications:

Name: _____

Title/Degree: _____

Email: _____

Name: _____

Title/Degree: _____

Email: _____

III. SECTION INFORMATION

CAHSAH requires that members be licensed in their sections. Please provide your license number for each section in which you provide services. If the license in a section is covered by another license, please re-enter that license number. (Please note: License numbers are 9 digits in length.)

Primary Section: _____
(Section type) (License #)

Secondary Sections:

- | | |
|---|---|
| <input type="checkbox"/> Home Care Aide (HCA) License # _____ | <input type="checkbox"/> Home Medical Equipment (HME) License # _____ |
| <input type="checkbox"/> Licensed Home Health (LHH) License # _____ | <input type="checkbox"/> Home Infusion Pharmacy (HIP) License # _____ |
| <input type="checkbox"/> Medicare Certified (MC) License # _____ | <input type="checkbox"/> Interdisciplinary Professional Services |
| <input type="checkbox"/> Hospice (H) License # _____ | |

Note: A copy of your state license is required, submit to CAHSAH by fax (916) 641-5881 or e-mail: membership@cahsah.org.

IV. CONDITIONS OF PARTICIPATION

1. Provider Membership in CAHSAH is open to direct providers of health and supportive services and products in the home.
2. Adherence to CAHSAH Code of Ethics.
3. Membership benefits begin with receipt of payment and continue for one year. Only employees of the member entity may utilize member benefits.
4. Dues are based on the number of licenses your agency holds and the number of branches/additional licensed locations serving your patients and clients. See page 2 for Dues Schedule.
5. Membership dues and voluntary contributions are non-refundable.
6. Dues payments to CAHSAH are not deductible as a charitable contribution for federal income tax purposes. However, dues payments may be deductible as an ordinary and necessary business expense, subject to an exclusion for lobbying activity. Because a portion of your dues is used for lobbying by CAHSAH, 16% of your dues is not deductible for income tax purposes.

I, as CEO, CFO or Executive Management, have read, understand and agree to abide by the Conditions of Participation. I further certify that I have accurately represented my agency's information.

Signature: _____ Date: _____

Name (please print): _____ Title: _____

PROVIDER DUES SCHEDULE

CAHSAH dues are based on the number of licenses your agency holds and the number of branches/additional licensed locations serving your patients and clients.

- **Minimum dues** \$1,500 and **Maximum dues** \$15,000
- **Home Care Aide** - \$1,500 for initial license and \$750 for each additional licensed locations
- **Home Health and Hospice** - \$1,500 per license and \$750 for each additional branch locations

Questions? Email: mlander@cahsah.org



V. CALCULATE YOUR DUES

Note: A copy of your state license is required, submit to CAHSAH by fax (916) 641-5881 or e-mail: membership@cahsah.org.

Agency: _____

(Step 1.) Enter # of licenses held (HCA, LHH, Hosp) _____ x \$1,500 **OR** = \$ _____

- If you are licensed separately to provide either HME or HIP services, enter \$1,500.
- If you are provide Interdisciplinary Professional Services, enter \$1,500.

(Step 2.) Enter # of branches/additional licensed locations _____ x \$750 = \$ _____

(Step 3.) Voluntary Contributions (Optional)

PAC (Political Action Committee) \$ _____

LAF (Legislative Action Fund) \$ _____

CLDF (CAHSAH Legal Defense Fund) \$ _____

PAC/LAF contributions are not deductible as charitable contributions. = \$ _____

(10-25% of your total dues suggested)

Total Membership Dues = \$ _____

VI. PAYMENT INFORMATION

By signing this application, you are committing to one (1) year of membership and payment of all monies due.

Please check for of payment: Check/Check No: _____ Visa MasterCard American Express

Credit Card # _____ Exp/Date: _____

Name (appears on card): _____

Billing Address: _____

City, State, Zip: _____

Signature: _____

PROVIDER DEMOGRAPHICS

Payments Accepted

HMO Private Insurance Veterans Administration
 Medi-Cal Private Pay Workers Comp
 Medicare TRICARE/CHAMPUS

Accreditations

ACHC
 CHAP
 JCAHO

List of Counties

Please check the counties in which your agency provides services.

Northern, CA

Alameda Marin Santa Cruz
 Butte Mendocino Shasta
 Colusa Modoc Sierra
 Contra Costa Napa Siskiyou
 Del Norte Nevada Solano
 El Dorado Placer Sonoma
 Glenn Plumas Sutter
 Humboldt Sacramento Tehama
 Lake San Francisco Trinity
 Lassen San Mateo Yolo
 Santa Clara Yuba

Central, CA

Alpine Mono
 Amador Monterey
 Calaveras San Benito
 Fresno San Joaquin
 Inyo Stanislaus
 Kern Tulare
 Kings Tuolumne
 Madera
 Mariposa
 Merced

Southern, CA

Imperial
 Los Angeles
 Orange
 Riverside
 San Bernardino
 San Diego
 San Luis Obispo
 Santa Barbara
 Ventura

List of Services

Please check the services your agency provides.

24/7 Delivery Services Hospice Oncology
 AIDS Patients Hospital & Clinical Consultation Oral Supplements
 Attendant/Companion/Sitter Household Management Perinatal/Pediatric Care
 Continuous Care Nursing Infusion Therapy Physical Therapy
 CPR Classes Medical Social Services Registered Dietician Support
 Elder Care/Geriatric Management Mental Health Services Rehabilitation Services
 Enteral Feeding Supplies & Equipment Multi-lingual Medical Social Services Respite Care
 Enterostomal Therapy Multi-lingual Staff Skilled Nursing
 Home Care Aide Nanny Care Speech Language Pathology
 Home Medical Equipment Occupational Therapy Speech Therapy

Organizational Information - Optional

To be used for statistical purposes only.

Statistics

Number of Full Time Employees: _____
 Number of Part Time Employees: _____
 Are you a member of your local Regional Council? _____
 Council Name: _____

Auspice

Please check one

For profit Free standing
 Non profit Hospital based
 Government

Membership Source:

How did you hear about CAHSAH: _____

BRANCHES/ADDITIONAL LICENSED LOCATIONS INFORMATION

Agency Name: _____ License #: _____
Mailing Address: _____
City, State, Zip: _____
Phone Number: _____ Fax: _____ E-mail: _____
Key Contact/Title: _____
Key Contact E-mail: _____

Agency Name: _____ License #: _____
Mailing Address: _____
City, State, Zip: _____
Phone Number: _____ Fax: _____ E-mail: _____
Key Contact/Title: _____
Key Contact E-mail: _____

Agency Name: _____ License #: _____
Mailing Address: _____
City, State, Zip: _____
Phone Number: _____ Fax: _____ E-mail: _____
Key Contact/Title: _____
Key Contact E-mail: _____

Agency Name: _____ License #: _____
Mailing Address: _____
City, State, Zip: _____
Phone Number: _____ Fax: _____ E-mail: _____
Key Contact/Title: _____
Key Contact E-mail: _____

Agency Name: _____ License #: _____
Mailing Address: _____
City, State, Zip: _____
Phone Number: _____ Fax: _____ E-mail: _____
Key Contact/Title: _____
Key Contact E-mail: _____

Agency Name: _____ License #: _____
Mailing Address: _____
City, State, Zip: _____
Phone Number: _____ Fax: _____ E-mail: _____
Key Contact/Title: _____
Key Contact E-mail: _____

If additional space is required, please use separate page and include with application.

California Association for Health Services at Home

Provider Membership Application



CAHSAH[®]

Shaping the Future of Home Care

3780 Rosin Court, Ste. 150, Sacramento, CA 95834
P: (916) 641-5795 | www.CAHSAH.org

Membership is one of the best investments for your business!

For more information, call 916-317-2907 or visit www.cahsah.org