



# ihca-ical

Idaho Health Care Association  
Idaho Center for Assisted Living  
PO Box 2623  
Boise, ID 83701

Phone: (208) 343 9735  
Fax: (208) 342-6891  
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## IDAHO HEALTH CARE ASSOCIATION - IDAHO CENTER FOR ASSISTED LIVING 2009 MEMBERSHIP APPLICATION

1. FACILITY NAME: \_\_\_\_\_
2. ADDRESS: \_\_\_\_\_
3. NUMBER OF LICENSED BEDS: \_\_\_\_\_
4. IDAHO STATE FACILITY LICENSE NUMBER: \_\_\_\_\_
5. TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_
6. ADMINISTRATOR: \_\_\_\_\_ Email: \_\_\_\_\_
7. IDAHO ADMINISTRATOR'S LICENSE NUMBER: \_\_\_\_\_
8. DNS (if applicable): \_\_\_\_\_ Email: \_\_\_\_\_
10. Medical Director (if applicable): \_\_\_\_\_  
Email: \_\_\_\_\_

**Dues are set annually and are billed in December of the year immediately preceding the year to which they apply. Three payment methods are allowed for full year members. Please choose a method that you will use for payment: (NOTE: INTEREST WILL BE APPLIED TO DELINQUENT ACCOUNTS AT A RATE SET BY THE IHCA-ICAL BOARD OF DIRECTORS AT ITS ANNUAL JANUARY MEETING.)**

- A. PAYMENT OF FULL ANNUAL DUES NOT LATER THAN **JANUARY 20TH** OF THE YEAR TO WHICH THEY APPLY. A TWO PERCENT (2%) REDUCTION IS ALLOWED FOR ANNUAL PAYMENT IN ADVANCE.
- B. QUARTERLY WITH 1/4TH OF THE ANNUAL AMOUNT OWING PAID BY **JANUARY 20TH** WITH THREE EQUAL AMOUNTS PAID ONE EACH MONTH BY APRIL 10TH, JULY 10TH, AND OCTOBER 10TH.
- C. TEN EQUAL INSTALLMENTS WITH THE FIRST PAYMENT DUE BY **JANUARY 20TH** AND BY THE 10TH OF THE MONTH EACH MONTH FOLLOWING UNTIL PAID IN FULL NO LATER THAN OCTOBER 31.

**IMPORTANT NOTE: In order to be recognized as having "member" status in IHCA-ICAL, the January 20th payment due date MUST be met. Your facility will NOT be listed in the membership directory nor will you get to pay the "member" rate for the Winter Workshop if IHCA-ICAL has not received payment for membership dues by this deadline!!**

11. MEMBERSHIP IN THE IDAHO HEALTH CARE ASSOCIATION-IDAHO CENTER FOR ASSISTED LIVING WILL BE AUTOMATICALLY RENEWED FOR A PERIOD OF ONE YEAR UNLESS:
- A. THE BOARD OF DIRECTORS ELECTS TO TERMINATE A FACILITY MEMBERSHIP FOR CAUSE, OR
  - B. A WRITTEN REQUEST FOR VOLUNTARY TERMINATION IS RECEIVED IN THE ASSOCIATION OFFICE PRIOR TO JANUARY 1 OF THE YEAR TO WHICH TERMINATION WILL APPLY.
12. DUES FOR NEW MEMBER APPLICATIONS RECEIVED ON OR AFTER JULY 1 WILL BE FIFTY PERCENT (50%) OF THE ANNUAL DUES AMOUNT. DUES PAID AT THAT TIME WILL BE IN THE FULL AMOUNT FOR THE REMAINDER OF THE YEAR AND ARE DUE UPON ACCEPTANCE OF THE APPLICATION.
13. ACCEPTANCE OF MEMBERSHIP IN IHCA-ICAL ALSO SIGNIFIES MEMBERSHIP IN THE AMERICAN HEALTH CARE ASSOCIATION (AHCA) FOR WHICH DUES ARE COLLECTED AND PAID BY IHCA-ICAL IN THE TOTAL ANNUAL DUES ASSESSMENT.

NOTE: IN KEEPING WITH FEDERAL LAW, A PORTION OF AHCA AND IHCA-ICAL DUES INVOLVING FEDERAL AND STATE LOBBYING WILL NOT BE DEDUCTIBLE IN 2009. THAT PORTION WILL BE PROMINENTLY IDENTIFIED ON THE DUES BILLING FORM.

14. 2009 Dues Breakdown:
- RALF - \$20.00 per licensed bed.....\$20.00 x \_\_\_\_\_ (# of licensed beds) = \_\_\_\_\_  
(\$9.50 State Dues; \$10.50 National Dues)
- ICF/MR - \$56.75 per licensed bed.....\$56.75 x \_\_\_\_\_ (# of licensed beds) = \_\_\_\_\_  
(\$36.15 State Dues; \$20.60 National Dues)
- SNF - \$56.75 per licensed bed.....\$56.75 x \_\_\_\_\_ (# of licensed beds) = \_\_\_\_\_  
(\$36.15 State Dues; \$20.60 National Dues)

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"IN MAKING APPLICATION FOR FACILITY MEMBERSHIP, I HEREBY AUTHORIZE IHCA-ICAL TO VERIFY INFORMATION PROVIDED BY ME."

AUTHORIZED REPRESENTATIVE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE RETURN THE COMPLETED APPLICATION AND PAYMENT BY JANUARY 10th TO:

IHCA-ICAL  
P.O. BOX 2623  
BOISE, IDAHO 83701-2623

Telephone # 208.343.9735 FAX # 208.342.6891