

**Benefits of The Center/
IHCA Membership**

- One year Associate membership
- Convention & Expo benefits:
 - One Standard exhibit booth with carpeting
 - Pre-event list of registered delegates
 - Business card drop box
 - Program book listing
- Electronic newsletters and other publications from the Association
- Seminar registration at member rate
- Reduced advertising rates in the Convention & Expo program book
- Networking opportunities at IHCA/ The Center regional meetings

**Philosophy and Code of
Ethics of The Center**

- 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

Date Rec'd _____
 Fee _____
 Check # _____
 Membership Exp. _____
 Region # _____

2021 The Center Associate/Affiliate Membership Application

(please type or print clearly)

Applicant (Company Name) _____ House District # _____
 Address _____ Senate District # _____
 City _____ Congressional District # _____
 State _____ Zip _____ County _____
 Phone () _____ Fax () _____
 Email _____ Website _____
 Contact Name _____ Title _____

Product/Service Categories

Please indicate two (2) product/service categories under which your company wishes to be listed in the "Associate Members by Product Category" section of the IHCA Membership Directory and Buyers' Guide. If you wish to be listed under additional categories, include \$25 per additional category. Your company will automatically be included in the alphabetical listing.

- | | |
|---|---|
| <input type="checkbox"/> Accounting/Financial Consulting Services | <input type="checkbox"/> Infection Control |
| <input type="checkbox"/> Activity Products | <input type="checkbox"/> Insurance and Risk Management Services |
| <input type="checkbox"/> Alarm/Emergency Response Systems | <input type="checkbox"/> Internet Products/Services |
| <input type="checkbox"/> Architecture/Design/Construction Services | <input type="checkbox"/> IV Therapy Products/Services |
| <input type="checkbox"/> Bathing/Patient Lift Systems | <input type="checkbox"/> Laboratory Services |
| <input type="checkbox"/> Billing Services | <input type="checkbox"/> Laundry Equipment/Services/Supplies |
| <input type="checkbox"/> Charting/Medication Distribution Systems | <input type="checkbox"/> Leasing Equipment |
| <input type="checkbox"/> Cleaning/Housekeeping Services and Products | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Clothing/Textiles/Linens | <input type="checkbox"/> Management and Consulting Services |
| <input type="checkbox"/> Communications | <input type="checkbox"/> Marketing Services and Products |
| <input type="checkbox"/> Computer Hardware/Software and Technology | <input type="checkbox"/> Medical Equipment/Supplies |
| <input type="checkbox"/> Continuum of Care Providers/Consultants | <input type="checkbox"/> Medical Waste Disposal |
| <input type="checkbox"/> Dental Supplies/Services | <input type="checkbox"/> Miscellaneous _____ (please specify) |
| <input type="checkbox"/> Dialysis Products/Services | <input type="checkbox"/> Mobile Diagnostic Services |
| <input type="checkbox"/> Dietary Consulting and Management Services | <input type="checkbox"/> Optometric/Vision Services |
| <input type="checkbox"/> Education/Training Programs and Services | <input type="checkbox"/> Payroll/Human Resource Systems |
| <input type="checkbox"/> Employment/Recruiting/Labor Relations/Staffing | <input type="checkbox"/> Pharmaceutical Supplies/Services |
| <input type="checkbox"/> Energy Services | <input type="checkbox"/> Podiatry Products/Services |
| <input type="checkbox"/> Environmental Equipment/Services | <input type="checkbox"/> Printing/Publications |
| <input type="checkbox"/> Fingerprinting/Background Checks | <input type="checkbox"/> Professional and Medical Services |
| <input type="checkbox"/> Floor Coverings/Surfaces | <input type="checkbox"/> Professional/Trade Association and Organizations |
| <input type="checkbox"/> Food Products/Equipment/Services | <input type="checkbox"/> Respiratory Therapy Products/Services |
| <input type="checkbox"/> Furniture/Room Furnishings | <input type="checkbox"/> Safety Equipment/Services |
| <input type="checkbox"/> Group Purchasing | <input type="checkbox"/> Therapy Services |
| <input type="checkbox"/> Hospice Services | <input type="checkbox"/> Transportation Vehicles/Services |
| <input type="checkbox"/> Incontinence/Skin Care Products and Services | <input type="checkbox"/> Wound Care/Management |

Payment Information

Membership Fee..... = \$ **1,500**
 Fee for additional categories indicated above..... = \$ _____
 Total Due = \$ _____

Application Process

- Annual fee of \$1,500 must accompany application in full.
- Mail signed application and check payable to the Illinois Health Care Association at the address below.
- Membership becomes effective upon approval by the IHCA Board of Directors and is automatically renewed unless either party terminates.

Facility Application

Please be advised that, per section 6033(e) of the Internal Revenue Code, The Center reasonably estimates that 29.84% of your 2021 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 Center, The Center-PAC, the Illinois Health Care Association, IHCA PAC, 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 Center/ Illinois Health Care Association and further agree to uphold the Code of Ethics of said Associations. If membership is canceled, the Associations must be given 30 days advance written notification. I further agree that if the Associations take legal action to collect unpaid dues, venue will be in Sangamon County, Illinois, and I will pay the costs of collection incurred by the Associations including reasonable attorneys' fees.

Signature _____ Date _____

The Center | 1029 South Fourth Street | Springfield, IL 62703-2224

800-252-8988 | 217-528-6455 | Fax 217-528-0452 | www.cddacs.org | mruicker@cddacs.org

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