California Association for Adult Day Services

APPLICATION FOR MEMBERSHIP

Approved 2017-01-24

Membership in CAADS is for the facility / business. Those operating more than one adult day services facility / business are required to place ALL into membership as a group, and must submit an Application for Membership for each. *Groups memberships are eligible for a dues discount based on the combined actual gross revenue of ALL adult day services in the Group.*

For additional membership applications, photocopy this form or go to the **JOIN NOW** tab at www.caads.org and download the form.

For assistance, please contact CAADS at (916) 552-7400 or caads@caads.org.

(Please print or type clearly)

APPLICANT (Applicant is the Facility / Business name. If pre-licensed / pre-vendorized, indicate "Site TBD")

Facility / Business Name *(doing business as)*: ______________________________

Facility / Business PHYSICAL ADDRESS: ______________________ City: ______________________

State: ____________ Zip Code + 4: ____________ – ________ County: ______________________

Facility / Business Tel: (________) ______________________ Facility / Business Fax: (________) ______________________

Facility / Business Email: ______________________ Facility / Business Web Site: ______________________
(Carefully distinguish between upper and lower case characters; hyphens, and underscores)

Previous Facility / Business Name(s) used by Applicant: ______________________________

Licensee *(as shown on facility license)*: ______________________________

Within the past 3 years, has: **Ownership changed?** ❑No ❑Yes/Date: __________ **Business name changed?** ❑No ❑Yes/Date: __________

PRIMARY CONTACT (Primary Contact is the ONE person to receive communications from CAADS / appear on membership roster)

First Name: ______________________ Last Name: ______________________ Credentials: __________

Position/Title: ______________________________ **Executive Director/CEO Level?** ❑Yes ❑No

MAILING ADDRESS: ______________________________ City: ______________________

State: ____________ Zip Code + 4: ____________ – ________ County: ______________________

Contact Tel: (________) ______________________ Ext: __________ Contact Fax: (________) ______________________

Contact Email: ______________________ **When possible, send CAADS information by:** (select one) ❑ **Email** ❑ **Fax**

FACILITY INFORMATION

Other facility, health license, local, state or federal certifications held by Applicant:

❑ ARF ❑ FQHC ❑ Home Health ❑ ICF/DD-H ❑ MSSP ❑ NF ❑ PACE ❑ RCFE ❑ Other: ______________

Are you in good standing with the licensing agency/s you listed above? ❑ Yes ❑ No

LEGAL STRUCTURE (Check only ONE)	**FIRST LEARNED ABOUT CAADS FROM** (Check only ONE)
❑ **GOVERNMENTAL ENTITY** **FOR PROFIT CORPORATION** (check type below) ❑ **LLC** (Limited Liability Company) ❑ **Proprietorship** ❑ **Partnership** ❑ **Joint Venture** ❑ **Other:** ______________________ ❑ **NON-PROFIT CORPORATION**	❑ **CAADS Office/Staff sent information** (mail / fax / email) ❑ **CAADS Web Site** (www.caads.org) ❑ **CA Department of Public Health Office / Staff** ❑ **CA Department of Aging Office / Staff** ❑ **CA Department of Health Care Services Office / Staff** ❑ **CA Department of Social Services Office / Staff** ❑ **Medi-Cal Managed Care Plan Office / Staff** ❑ **Referred by:** ______________________________ (Name of person and organization who referred you to CAADS)

- Licensed providers **MUST** **submit photocopy of their facility license/s with membership application** AND **proof of Actual Gross Revenue (AGR)**. *Proof of AGR for the most recent fiscal year end is required annually, at time of membership renewal.*
- As a **free benefit of membership** and service to the public, licensed Adult Day Health Care / Community Based Adult Services, Adult Day Programs, and Adult Day Vendorized Programs are listed under **FIND A CENTER** at www.caads.org.
  Only CAADS Members are listed. Complete the Web Listing Form or call CAADS for more information.

MEMBERSHIP CLASSIFICATIONS (CAADS reserves the right to classify Applicant according to the appropriate category)

Complete the ADULT DAY SERVICES OR ASSOCIATE section below.
If you own/operate multiple adult day services facilities / businesses, you must submit a separate membership application for each.

For current Membership Dues Rates/Benefits, go to the **JOIN NOW** tab at www.caads.org or contact CAADS at (916) 552-7400 / caads@caads.org. *Financial information submitted to CAADS is used solely to verify membership dues rate, and is kept strictly confidential.*

ADULT DAY SERVICES

Facility / Program Type: *Check ALL that apply*

- ❑ **Adult Day Health Care** (Medical model)
- ❑ **Adult Day Program** (Non-medical model)
- ❑ **Alzheimer's Day Care Resource Center**
- ❑ **Community-Based Adult Services** (Medical model for Medi-Cal beneficiaries)
- ❑ **Adult Day Vendorized Program** (Non-medical model; Regional Center clients)
- ❑ **Program of All-Inclusive Care for the Elderly**

Licensure / Vendorization Status: *Check ONE and complete that section*

❍ **Pre Licensed / Vendorized** *Fiscal Year End: ___/___/_____ License / Vendor Application Submitted: ___/___/_____ Licensure Anticipated: ___/___/____*
NON-VOTING Membership. If within 90 days of licensure, join as **New Licensee / Owner**. Upon licensure, you must provide CAADS with a photocopy of the facility license.
Those who already own/operate a licensed adult day services facility are ineligible for Pre-Licensed membership unless all their licensed facilities are members of CAADS.

❍ **New Licensee / Owner** Fiscal Year End (FYE): ___/___/_____ ADHC Licensed: ___/___/______ ADHC Licensed Capacity: _______
VOTING Membership. Tiered dues rates for years 1, 2, 3.
Photocopy of Facility License must accompany Membership Application ADP Licensed: ___/___/________ ADP Licensed Capacity: _______

❍ **Licensed / Vendorized Provider** Fiscal Year End (FYE): ___/___/_____ ADHC Licensed: ___/___/_______ ADHC Licensed Capacity: _______
VOTING Membership. Sliding scale dues rate based on most recent FYE actual gross revenue.
Copy of Facility License and proof of Actual Gross Revenue (AGR) for most recent FYE **must** accompany Membership Application.* ADP Licensed: ___/___/________ ADP Licensed Capacity: _______
Actual Gross Revenue for most recent Fiscal Year End: $ _______________ ADVP Approved: ___/___/________ ADVP Program Capacity: _______

*Submit copy of FYE Financial/ P&L *(1-page Revenue summary)*, ***OR*** copy of most recent Tax Return *(1-page Income summary). AGR proof must be submitted annually at renewal time.*

ASSOCIATE

Classifications: Check ONE, and attach description of your product / service / mission *(35 words max)*

❑ **Allied Community / Government Organization** NON-VOTING Membership
Community based or government health or social services organization, association or network:
Examples: ADS network | Area agency on aging | association | caregiver resource center | educational institution
government department / agency | MSSP | regional center | residential care facility |
Those providing or seeking licensure / vendorization to provide adult day services are ineligible for Allied Community / Government Organization membership.
See Membership Dues / Benefits sheets specific to: ADHC | ADP | ADVP

❑ **Consultant** NON-VOTING Membership
Business offering adult day start-up or operational consulting services.
Consultants with ownership / employment relationships with one or more adult day services providers must bring those into membership to become eligible for Associate Consultant Membership

❑ **Main Office** NON-VOTING Membership
Main Office contact for an adult day services center / business already in membership.
Limited to one person from the main office, provided ALL adult day services centers / businesses owned or managed by main office are in membership with CAADS.

❑ **Health Care Provider Partner** NON-VOTING Membership
Licensed Health Care Providers.
Examples: Home health agency | hospital | IPA | Knox-Keene licensed plan | nursing facility

❑ **Vendor** NON-VOTING Membership
Business offering products / services to adult day services industry.
Vendors with ownership/employment relationships with one or more adult day services centers/programs must bring those into membership to become eligible for Associate-Vendor Membership.

DISCLOSURES (ALL applicants must complete)

1. **Has Applicant ever been a member of CAADS?** ❑ No ❑ Yes
   If YES, under what center or business name: ______________________________
2. **Has Applicant, officer, director, employee or person with an ownership or control interest in Applicant ever been convicted of any felony or misdemeanor involving fraud, moral turpitude, or abuse of any kind?** ❑ No ❑ Yes
   If YES, please explain here or attach sheet: ______________________________
3. **Has Applicant, officer, director, employee or person with an ownership or control interest in Applicant ever been found liable for fraud, moral turpitude, or abuse of any kind in any civil proceeding?** ❑ No ❑ Yes
   If YES, please explain here or attach sheet: ______________________________
4. **Has Applicant, officer, director, employee or person with an ownership or control interest in Applicant or any health care entity, community care facility, or vendorized adult day program owned or operated by Applicant been subject to formal disciplinary action by federal, state, or local licensing or regulatory authorities within the last 5 years?** ❑ No ❑ Yes
   If YES, please explain here or attach sheet: ______________________________

I certify that the contents of this application are accurate and complete, and I will advise the Association of significant changes in operations, ownership, or material changes to the membership information. I agree to abide by the Code of Ethics, Bylaws, and Policies of the Association including decisions of the Ethics Committee, Membership Committee and other duly constituted CAADS Committees. I agree that membership may be terminated immediately if application contains false or misleading statements. I agree to hold CAADS harmless concerning disciplinary action or termination of membership.

Signature of Authorized Officer or Agent ______________________________ Title ____________________

Print or Type Name and Title ______________________________ Date ____________________

Membership application cannot be processed until completed application, attachments and payment are received.

Thank you for your interest in CAADS and support of quality Adult Day Services programs!

CAADS

California Association for Adult Day Services

Remittance Slip

Revised 10/9/2016

Amount Enclosed: $__________________

Amount indicated above is based on the ***CAADS Membership Dues Rates / Benefits Sheet*** for:

☐ ADHC Membership ☐ ADP Membership ☐ ADVP Membership ☐ Associate Membership

Center / Business Name (DBA): ____

❒ **Enclosed is membership dues amount shown above.** *(Please make check payable to "CAADS")*

❒ **Charge membership dues amount shown above to my:**

- ❑ **MasterCard** (credit or debit card)
- ❑ **Visa** (credit or debit card)
- ❑ **Discover** (credit card)

(Sorry, we cannot accept American Express or other cards not listed above.)

Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

CVV Code: ___ ___ ___ **Card Expiration Date:** ____________________________

Cardholder Name: ____
(Please Print)

Cardholder Street Address: ____ ZIP: _____________
(Please Print)

Authorized Signature: ____

Cardholder's Telephone Number: (________) _______________________

🖂 Please Return Remittance Slip with Application for Membership to:

CAADS
1107 9th Street, Suite 701
Sacramento, CA 95814-3610
Telephone: (916) 552.7400 ~ Fax: (866) 725.3123

◆ CAADS' Returned Check Fee is $50.00 ◆

- Returned checks will be referred to the appropriate legal authorities.
- Checks without a number or account holder imprint will not be accepted for payment.
- If a charge card is declined, an alternative charge card may be submitted for verification, or a cashier's check or money order will be required in order for the request to be honored.
- It is your responsibility to assure that sufficient funds are available for the transaction.

CAADS reserves the right to refuse service or membership privileges to any individual or company that writes a check that is returned for insufficient funds or whose credit/debit card is declined.