APPLICATION FOR MEMBERSHIP

Revised 2021-10-20

California Association for Adult Day Services | 1107 9th Street, Suite 701 | Sacramento, CA 95814
T: 1.916.552.7400 ◆ F: 1.866.725.3123 ◆ E: caads@caads.org ◆ W: https://www.caads.org

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 1 (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 / organization that 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.

CAADS RESERVES THE RIGHT TO CLASSIFY APPLICANT ACCORDING TO THE APPROPRIATE CATEGORY

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 1 (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 (ADS) Membership Options (Complete the section that best describes the status of your ADS center)

❑ **Pre-licensed / Pre-vendorized:** *Non-Voting* | Annual Membership: Year 1 Dues ▪ Year 2 Dues

Individual / business considering or in the process of applying for an ADS facility license or Regional Center vendorization

If your center becomes licensed, you must provide CAADS with a photocopy of the facility license. Pre-licensed membership not available to those who own / operate other ADS centers unless all centers in the group are in membership with CAADS.

Fiscal Year End: ___/___/_____ **Date Pre-Screening Application Submitted:** ___/___/_____ **Date Facility License/ Vendorization Application Submitted:** ___/___/_____ **Date Facility License/ Vendorization Anticipated:** ___/___/_____

❑ **Newly Licensed:** *Voting* | Annual Membership: Year 1 Dues ▪ Year 2 Dues ▪ Year 3 Dues

Licensed less than 4 years; photocopy of facility license must accompany Application for Membership

Fiscal Year End: ___/___/_____ **ADHC License Date:** ___/___/_____ **ADHC License Capacity:** ____ **ADP License Date:** ___/___/_____ **ADP License Capacity:** ____

❑ **Licensed/Vendorized:** *Voting* | Annual Membership: Dues on a sliding scale based on Actual Gross Revenue for most recent FYE

Licensed 4 or more years. Photocopy of facility license AND proof of most recent FYE Actual Gross Revenue* must accompany Application for Membership.

Fiscal Year End: ___/___/_____ **ADHC License Date:** ___/___/_____ **ADP License Date:** ___/___/_____ **ADVP Vendorization Date:** ___/___/_____

***Most Recent FYE Gross Revenue $:** _____ **ADHC License Capacity:** _____ **ADP License Capacity:** ____ **ADVP Program Capacity:** _____

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

Adult Day Services (ADS) Center Type / Program (Check ALL that apply)

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

Associate Membership Options (Check just ONE, and attach description of product / service / mission – 35 words max)

❑ **Allied Community / Government Organization |** Non Voting | Annual 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 ADS licensure / vendorization are ineligible for Allied Community / Government Organization membership. ***See* ADHC, ADP, ADVP Membership.**

❑ **Consultant:** *Non-Voting* | Annual Membership

Business offering adult day start-up or operational consulting services

Consultants with ownership / employment relationships with one or more ADS centers must bring those centers into membership to be eligible for Consultant Membership.

❑ **Main Office:** *Non-Voting* | Annual 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* | Annual Membership

Licensed health care providers

Examples: **Home health agency ▪ hospital ▪ IPA ▪ Knox-Keene licensed plan ▪ nursing facility**

❑ **Vendor:** *Non-Voting* | Annual Membership

Business offering products / services to adult day services industry

Vendors with ownership / employment relationships with one or more ADS centers must bring those centers into membership to be eligible 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!

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REMITTANCE SLIP

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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) ❑ **American Express** (credit card)

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

3-digit Security 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 ~ Email: caads@caads.org

◆ 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.