



California Association for Adult Day Services

APPLICATION FOR MEMBERSHIP

Revised 2012-01-17

Membership in CAADS is for a facility/business. Licensees operating more than one facility are required to place ALL facilities into membership as a group, and an Application for Membership for each adult day services facility must be submitted in order for the application to be processed. Groups are eligible for a dues discount based on the combined actual gross revenue of all facilities. Photocopy this form or go to www.caads.org and click on the *Join Now* tab to download additional membership applications. For assistance, please call CAADS at (916) 552-7400.

(Please print or type clearly)

APPLICANT (Facility/Business)

Facility Name/DBA: _____

Facility Physical Address: _____ City: _____

State: _____ Zip Code + 4: _____ - _____ County: _____

Facility Telephone: (_____) _____ Facility Fax: (_____) _____

Facility Email: _____ Facility Web Site: _____
(Please 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: (1) Ownership change? No Yes, (Date) _____ (2) Business name change? No Yes, (Date) _____

CONTACT (Person to receive CAADS communications and be listed on membership roster)

First Name: _____ Last Name: _____

Position/Title: _____ Executive Director/CEO Level? Yes No

Contact Mailing Address: _____ City: _____

State: _____ Zip Code + 4: _____ - _____ County: _____

Contact Telephone: (_____) _____ Extension: _____ Contact Fax: (_____) _____

Contact Email: _____ Whenever possible, send CAADS information by: (select one) Email Fax Postal

FACILITY INFORMATION (For providers only)

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

ARF FOHC 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)
<input type="checkbox"/> GOVERNMENTAL ENTITY <input type="checkbox"/> FOR PROFIT CORPORATION (check type below) <input type="checkbox"/> LLC (Limited Liability Company) <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: _____ <input type="checkbox"/> NON-PROFIT CORPORATION	<input type="checkbox"/> CAADS Office/Staff sent information (mail / fax / email) <input type="checkbox"/> CAADS Web Site (www.caads.org) <input type="checkbox"/> CA Department of Public Health Office/Staff <input type="checkbox"/> CA Department of Aging Office/Staff <input type="checkbox"/> CA Department of Social Services Office/Staff <input type="checkbox"/> Referred by: _____ (Name of person and organization who referred you to CAADS)

- Licensed providers are required to submit a copy of their facility license/s with membership application.
- As a member benefit and service to the public, each licensed Adult Day Services facility and Associate category member is encouraged to complete a CAADS Web Site Listing Form. Only CAADS Members are eligible for a listing. For more information, call CAADS at (916) 552-7400.

Under Adult Day Service or Associate section below, please indicate category for which Applicant qualifies. If you operate multiple facilities under your license, all facilities must apply for membership; use a separate application form for each. *Financial information submitted to CAADS is used for the sole purpose of verifying membership dues rate, and is kept strictly confidential.* See *Membership Categories, Dues and Benefits* for ADHC, ADP or Associate membership, or contact CAADS for assistance: (916) 552-7400. *CAADS reserves the right to classify Applicant according to appropriate category.*

ADULT DAY SERVICE (Check ALL Program Types that apply, then complete appropriate Licensure Status section)

- Adult Day Health Care/ADHC** **Community-Based Adult Services/CBAS** **Alzheimer's Day Care Resource Center/ADCRC**
 Adult Day Program/ADP **Developmental Disabilities Program/DD** **Program of All-Inclusive Care for the Elderly/PACE**

PRE-LICENSED: Fixed dues rate for maximum of 3 years **NON VOTING MEMBER**

Date Licensing Application Submitted: _____ Date Licensure Anticipated: _____ Date Fiscal Year Ends: _____

Note: You will be required to provide CAADS with a copy of facility license after licensure is granted. If within 90 days of licensure, join at Newly Licensed/New Ownership level. 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.

NEWLY LICENSED / NEW OWNERSHIP: Tiered dues rates for years 1, 2 and 3 **VOTING MEMBER**

Date Licensed: ADHC: ___/___/___ ADP: ___/___/___ Licensed Capacity: ADHC: _____ ADP: _____ Date Fiscal Year Ends: ___/___/___

Submit with Application: Copy of facility license (required) Web Listing Form (recommended)

LICENSED: Sliding scale dues rate based on actual gross revenue for providers licensed 4 or more years **VOTING MEMBER**

Date Licensed: ADHC: ___/___/___ ADP: ___/___/___ Licensed Capacity: ADHC: _____ ADP: _____ Date Fiscal Year Ends: ___/___/___

Actual Gross Revenue for most recent Fiscal Year End: \$ _____

Submit with Application: Copy of facility license (required) Proof of actual gross revenue for most recent fiscal year end -- copy of Cost Report Section G for ADHC facilities or copy of Consolidated Profit & Loss Statement for ADP facilities -- (required) Web Listing Form (recommended)

ASSOCIATE (Describe product/service/mission below or attach sheet – maximum 35 words)

CONSULTANT: Fixed dues rate **NON VOTING MEMBER**

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

VENDOR: Fixed dues rate **NON VOTING MEMBER**

Business offering products/services to adult day services industry. Vendors with ownership/employment relationships with one or more adult day services facilities must bring those facilities into membership before becoming eligible for Associate-Vendor Membership.

ALLIED / GOVERNMENT ORGANIZATION: Fixed dues rate **NON VOTING MEMBER**

Health or social services organization, community based long-term care organization, association or network:

Nursing home, hospital, residential care facility for the elderly, adult residential facility, physician practice, managed care, intermediate care facility, home health agency, area agency on aging, government department/agency, MSSP, Linkages, caregiver resource center, regional center, network, association, educational institution, etc.

Those operating, providing or seeking licensure for an adult day services program are ineligible for Allied/Government Organization membership. See ADHC and/or ADP membership categories, dues and benefits.

CORPORATE OFFICE: Fixed dues rate **NON-VOTING MEMBER**

Corporate Office contact for an adult day services facility already in membership. Limited to one representative from a corporate office, provided ALL adult day services facilities owned/managed by the corporate office are in membership with CAADS.

DISCLOSURES (ALL applicants must complete)

1. **Has Applicant ever been a member of CAADS?** No Yes
If YES, under what facility/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 or community care facility 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 will advise the Association of significant changes in operations, ownership, or material changes to the membership information. I agree to abide in 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 for your support of quality Adult Day Services programs!



CAADS

California Association for Adult Day Services

Remittance Slip

Revised 2009-10-29

Membership Dues Amount: \$ _____

Facility 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: _____

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.