

2010 MEMBERSHIP APPLICATION - DD Providers

California Association of Health Facilities

Developmental Services



Committed
to choice
and quality
of life

California Association of Health Facilities (CAHF) - Developmental Services Conference

Agency _____		Phone _____
Name of Home _____		Fax _____
Street _____	City _____	ZIP _____
Owner/Contact _____		Owner E-mail _____
<u>Number of Homes</u>	<u>Number of Beds</u> (Clients/Consumers)	<u>Website</u> _____
ICF-DD _____	_____	<p>PLEASE NOTE: If you have <u>more than one</u> home, please list the specific information for each home in the space provided on the back (or next page) of this form. Thank you.</p>
ICF-DD "H" _____	_____	
ICF-DD "N" _____	_____	
ICF-DD "CN" _____	_____	

CAHF will send you a monthly dues payment coupon book, so no need to send money now.

2010 Dues: For 10 beds or more = \$4.54 per bed/per month
 For less than 10 beds = \$3.67 per bed/per month, plus \$8.33 each month

If you pay the year in full by Feb. 28th, you receive a 4% discount on the CAHF mandatory dues.
 If you have homes in any of the following counties - Fresno, Kings, Madera, Mariposa or Tulare – your yearly dues will be an additional \$1.00 per bed per year to cover CAHF local chapter dues.

You may fax this application to 916-441-6441, to the attention of Bev Allen, or mail it to: CAHF, 2201 K Street, Sacramento, CA 95816. For questions about membership, please contact Bev Allen at (916) 441-6400, ext. 107.

SIGNATURE REQUIRED HERE → Application authorized by: _____

NOT OPEN YET? Join CAHF as an ***“Under Construction”*** member and receive member benefits at the reduced rate of \$200 a year. (When your home opens, you then pay facility (“per bed”) membership dues. **If you are open for business now, you cannot use this category**). To join as ***“Under Construction,”*** complete this section (and the section at the top of the page) and send to CAHF with a check for \$200 or submit your credit card info below.

VISA___ MC___ AMEX___ Card # _____ Exp _____

Signature _____ Date _____

Print name _____ Title _____

Amount to be charged is \$200.00. Remember to fill in the information requested at the top of this page.

Signature on this application serves as an agreement between CAHF and the applicant to pay dues and assessments as set yearly at the CAHF House of Delegates. It also serves as permission for CAHF to fax/e-mail items of interest to the applicant and/or their representatives.



If the spaces below aren't enough to list all your homes, you may photocopy this page. Thank you.

Name of Home: _____ Phone _____
Address _____ City _____ ZIP _____
Administrator/Contact _____ Fax _____
Please check one: ICF/DD ICF/DD-H ICF/DD-N ICF/DD-CN Number of beds _____

Name of Home: _____ Phone _____
Address _____ City _____ ZIP _____
Administrator/Contact _____ Fax _____
Please check one: ICF/DD ICF/DD-H ICF/DD-N ICF/DD-CN Number of beds _____

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Administrator/Contact _____ Fax _____
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Name of Home: _____ Phone _____
Address _____ City _____ ZIP _____
Administrator/Contact _____ Fax _____
Please check one: ICF/DD ICF/DD-H ICF/DD-N ICF/DD-CN Number of beds _____

CALIFORNIA
ASSOCIATION OF
HEALTH FACILITIES



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