

## 2012 CAHF 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 _____		
Contact E-mail _____		Website _____
<u>Number of Homes</u>	<u>Number of Beds</u> (Clients/Consumers)	<p><b>PLEASE NOTE:</b> If you have <u>more than one</u> home, please list just your agency information on this page and the information on your homes on the next or back page of this form.</p>
ICF-DD _____	_____	
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.**

2012 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. 28<sup>th</sup>, 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 916-446-4454, 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 800-347-5547, ext. 107

**SIGNATURE REQUIRED HERE** ⇨ Application authorized by: \_\_\_\_\_

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 representative



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: <input type="checkbox"/> ICF/DD <input type="checkbox"/> ICF/DD-H <input type="checkbox"/> ICF/DD-N <input type="checkbox"/> ICF/DD-CN    Number of beds _____

  

Name of Home: _____ Phone _____
Address _____ City _____ ZIP _____
Administrator/Contact _____ Fax _____
Please check one: <input type="checkbox"/> ICF/DD <input type="checkbox"/> ICF/DD-H <input type="checkbox"/> ICF/DD-N <input type="checkbox"/> ICF/DD-CN    Number of beds _____

  

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Address _____ City _____ ZIP _____
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Please check one: <input type="checkbox"/> ICF/DD <input type="checkbox"/> ICF/DD-H <input type="checkbox"/> ICF/DD-N <input type="checkbox"/> ICF/DD-CN    Number of beds _____

  

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Please check one: <input type="checkbox"/> ICF/DD <input type="checkbox"/> ICF/DD-H <input type="checkbox"/> ICF/DD-N <input type="checkbox"/> ICF/DD-CN    Number of beds _____