

2012 IACP Agency Membership Form

An agency must complete this application form and be approved by the IACP Board of Directors before they may participate as a member of the association. Information from this form will be published in the IACP Resource Directory.



Agency Name _____ County _____

Street Address _____

P.O. Box _____

City, State, Zip _____

Phone Number _____ Fax Number _____

Agency Website _____ Year Founded/Incorporated _____

Primary Contact _____ Title: _____

E-mail Address _____

Secondary Contact _____ Title: _____

Additional Contact _____ Title: _____

Accreditation/Licensure _____ Exp. Date _____

Number of Full-time Staff / FTEs (Include all locations) _____

Total Number of Employees (Include all locations) _____

Total Annual Operating Budget (most recent year) _____

If your agency provides services in multiple locations in Iowa, please provide all additional mailing addresses along with names and email addresses for the contact person(s) on a separate sheet of paper.

Signature _____ Date _____
(Person completing the application.)

Title _____ Phone _____

Deadline for Dues is December 31, 2011

An agency applying for membership shall submit its application and full dues payment to the IACP office no later than December 31, 2011. Partial payment may be made according to the following schedule:

- **December 31, 2011 – Submit two-thirds of the full amount of 2012 dues.**
- **March 31, 2012 – Submit the final one-third of 2012 dues.**

Any agency with an outstanding balance or unpaid dues after April 1, 2012 will have all membership privileges suspended until such time as they have made arrangement for full payment of dues.

Indicate those counties in which you are currently providing services:

Counties: _____

Indicate the variety of services that are currently being provided by your agency:

Vocational Services

___ Supported Employment ___ Day Habilitation ___ Pre- Vocational ___ Work Services

Residential Services

___ ICF ___ Respite ___ CHORE ___ CSALA
___ RCF ___ Hourly SCL ___ Daily SCL ___ Residential Treatment
___ Habilitation ___ CDAC ___ Shelter Service ___ Day Habilitation

Mental Health Related Services

___ CMHC ___ Remedial ___ CSS ___ Substance Abuse Treatment
___ Habilitation ___ Psychiatry ___ IPR ___ EAP ___ PACE
___ ACT ___ Case Mgmt. ___ SCL ___ Homeless Outreach

Children's Services

___ Residential ___ IMMT ___ SCL
___ Foster Care ___ PMIC ___ Respite

Waiver Services

___ ID Waiver ___ Children's Mental Health Waiver ___ Physical Disability Waiver
___ BI Waiver ___ HIV Waiver ___ Elder Waiver ___ Ill and Handicapped Waiver

Other:

___ Consumer Choice Option ___ Money Follows the Person

Total number of individuals served in the most recent fiscal year: _____

IACP Dues Schedule

The dollar amount of your annual dues is determined by the Gross Staff Salaries of your individual agency. Application for IACP Membership is open to all fully accredited community-based organizations that provide one or more of a variety of diverse services to children or adults with mental illness or mental health related issues, mental retardation, brain injury, or other developmental disabilities.

We're pleased that this year will mark the association's 17th consecutive year without an increase in dues.

Category	Your Staff Salaries	Your IACP Dues
1	\$0 - \$350,000	\$1,300
2	\$350,001 - \$750,000	\$1,550
3	\$750,001 - \$1,000,000	\$1,800
4	\$1,000,001 - \$1,500,000	\$2,050
5	\$1,500,001 - \$2,000,000	\$2,300
6	\$2,000,001 - \$2,500,000	\$2,550
7	\$2,500,001 - \$3,000,000	\$2,800
8	\$3,000,001 - \$3,500,000	\$3,050
9	\$3,500,001 - \$4,000,000	\$3,300
10	\$4,000,001 - \$5,000,000	\$3,550
11	\$5,000,001 - \$6,000,000	\$3,800
12	\$6,000,001 - \$7,000,000	\$4,050
13	\$7,000,001 - \$8,000,000	\$4,300
14	\$8,000,001 - \$9,000,000	\$4,550
15	\$9,000,001 - \$10,000,000	\$4,800
16	\$10,000,001 - \$11,000,000	\$5,050
17	\$11,000,001 - \$12,000,000	\$5,300
18	\$12,000,001 - \$13,000,000	\$5,550
19	\$13,000,001 - \$14,000,000	\$5,800
20	\$14,000,001 - \$15,000,000	\$6,050
21	\$15,000,001 - \$16,000,000	\$6,300
22	\$16,000,001 - \$17,000,000	\$6,550
23	\$17,000,001 - \$18,000,000	\$6,800
24	\$18,000,001 - \$19,000,000	\$7,050
25	\$19,000,001 - \$20,000,000	\$7,300
26	\$20,000,001 - \$21,000,000	\$7,550
27	\$21,000,001 - \$22,000,000	\$7,800
28	\$22,000,001 - \$23,000,000	\$8,050
29	\$23,000,001 - \$24,000,000	\$8,300
30	\$24,000,001 - \$25,000,000	\$8,550
31	\$25,000,001 or more	\$8,800

In order to better monitor the wide variety of events affecting Iowa providers at the national level, IACP currently belongs to the following national organizations:

- NCCBH - The National Council for Community Behavioral Health
- ANCOR - The American Network of Community Options and Resources
- ACCSES - The Voice of Disability Service Providers
- NABIS - The North American Brain Injury Society

Advisory Committee Membership

Please Read Carefully: IACP operates with a system of advisory committees and standing committees to further communication between our members, the Board of Directors, and IACP staff. Membership of the advisory committees is based on the type of services each agency provides.

Based on the services your agency provides, which advisory committee(s) do you expect your representatives to participate in? (Check all that apply to your agency.)

Advisory Committee Options:

Residential Vocational Brain Injury Children's Mental Health

Dues Calculation

Your FY 2011 Gross Staff Salaries *(Please enclose a copy of your most recent audit.)* _____

Your IACP Dues *(View chart on page 3.)* _____

Application Fee of \$100 *(Required for new members only.)* _____

Total IACP Dues Payment: _____

Method of Payment

Paying by Check: Check # _____ *(Payable to Iowa Association of Community Providers; Fed. ID: 42-1048282)*

Paying by Credit Card: *(Check One)* VISA Mastercard

Card # _____ Exp. Date: _____ 3 Digit Code: _____

Cardholder's Name: _____ Cardholder's Email: _____

Credit Card Billing Street Address: _____

Credit Card Billing City: _____ State: _____ Zip: _____

Cardholder's Signature: _____

DUES DEADLINE: December 31, 2011. Form can be completed online at: www.iowaproviders.org

**If paying by check, print and sign, then mail to: IACP, 7025 Hickman Road; Suite 5, Urbandale, Iowa 50322
If paying by credit card, print and sign, then fax to: (515) 270-1035**

For IACP Use Only

Date Received: _____ Date Processed: _____ Annual Dues: _____

Payment Type: Check # _____

Credit Card # _____

Credit Card Type: VISA Mastercard