IACP
Iowa Association of Community Providers

2024 IACP Organization Membership Form

An organization must complete this application form and be approved by the Membership Services committee before they may participate as a member of the Association.

Organization Name _____ County _____

Street Address _____

PO Box _____

City, State, Zip _____

Phone Number _____ Fax Number _____

Organization Website _____ Year Founded/Incorporated _____

Executive Director Name _____ Executive Director Email _____

CFO Name _____ CFO Email _____

HR Director Name _____ HR Director Email _____

Primary Contact for Organization _____ Title _____

Primary Contact Email Address _____ Phone _____

Business Entity Type

◯ Nonprofit ◯ For-Profit IRS Code _____

Accreditation/Licensure _____ Exp. Date _____

* Total Number of Employees *(include all locations)* _____

* Total Number of Persons Served *(include all services)* _____

* Total Annual Budget *(most recent year)* _____

* Total Gross Staff Salary *(most recent year)* _____

What percentage of your revenue is Medicaid? _____ %

If your organization 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.

Executive Director Signature _____ Date _____

CFO/Finance Director Signature _____ Date _____

* These questions must be answered in order to process your membership application. Thank you!

Indicate the counties you are currently providing services:

Counties: _____

_____

Indicate the variety of services currently being provided by your organization:

Employment Services

- ◯ Day Habilitation
- ◯ Pre-Vocational
- ◯ Supported Employment
- ◯ Work Services
- ◯ IVRS

Residential Services

- ◯ Assisted Living
- ◯ CDAC
- ◯ CHORE
- ◯ CSALA
- ◯ ICF
- ◯ Daily SCL
- ◯ Hourly SCL
- ◯ Home-Based Habilitation
- ◯ Respite
- ◯ Shelter Service
- ◯ Residential Treatment
- ◯ RCF – please list the number of licensed beds _____
- ◯ RCF/ID – please list the number of licensed beds _____
- ◯ RCF/PMI – please list the number of licensed beds _____

Behavioral Health Related Services

- ◯ ACT
- ◯ CMHC
- ◯ CSS
- ◯ Case Mgmt.
- ◯ Counseling
- ◯ Psychiatry
- ◯ Homeless Outreach
- ◯ Mental Health Outreach
- ◯ IHH
- ◯ IPR
- ◯ Substance Use Disorder
- ◯ In-Home Family Therapy
- ◯ PACE
- ◯ BHIS
- ◯ Family Counseling & Training
- ◯ SCL
- ◯ Habilitation
- ◯ EAP
- ◯ Family & Community Support Services

Children's Services

- ◯ BHIS
- ◯ IMMT
- ◯ PMIC
- ◯ Residential
- ◯ Hourly SCL
- ◯ RB SCL
- ◯ Respite

Waiver Services

- ◯ BI Waiver *(# individuals served)*_____
- ◯ Children's Mental Health Waiver *(# individuals served)*_____
- ◯ Elderly Waiver *(# individuals served)*_____
- ◯ Health and Disability Waiver *(# individuals served)*_____
- ◯ HIV Waiver *(# individuals served)* _____
- ◯ Physical Disability Waiver *(# individuals served)*_____
- ◯ ID Waiver *(# individuals served)* _____

Other

- ◯ Consumer Choice Option
- ◯ Money Follows the Person
- ◯ Community Neurobehavioral Services
- ◯ Outpatient services (OT, PT, Speech, other)
- ◯ Transportation
- ◯ ABA
- ◯ Child Welfare

Annual Conference

The IACP Annual Conference is *May 7-9, 2024*. Please see our website for details.

IACP Members receive membership with NCCBH and ANCHOR. These two national associations representing the national interests of IACP members.

- NCCBH – The National Council for Community Behavioral Health
  - www.thenationalcouncil.org
- ANCOR – The American Network of Community Options and Resources
  - www.ancor.org

Dues Calculation

- IACP member dues are based on annual gross staff salaries. The member dues schedule is included on the following page.
  - Please submit a copy of your most recent audit, 990 or a year-end financial statement for dues calculation.
- A $100 application fee will be applied for new member applications.

Method of Payment

◯ **Paying by Check:** Check # _____ *(Payable to Iowa Association of Community Providers; Fed. ID: 42-1041048282)*

◯ **Paying by Credit Card:** ◯ VISA ◯ MasterCard

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

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

Credit Card Billing Street Address:_____

Credit Card Billing City: _____ State: _____ Zipcode: _____

Cardholder's Signature: _____

If paying by check, please send check and completed application to: IACP, 7025 Hickman Road – Suite 5, Urbandale, Iowa 50322.
If paying by credit card, complete credit card information above on application and scan/email to Susan Seehase at sseehase@iowaproviders.org. Completed application must accompany payment for membership to be processed.

Relentlessly advocating for Iowa providers to build healthy communities so that

One day, all Iowans will live, learn and work in their community of choice.

IACP 2024 Dues Schedule

The dollar amount of your annual dues is determined by the Gross Staff Salaries of your organization. Verification of the dues level will be made through applicants providing a copy of the most recent audit completed, 990 or a financial statement representing the conclusion of a twelve (12) month period.

TIER A		
Category	**Your Gross Staff Salaries**	**Your IACP Dues**
1	$1 - $499,999	$1,615
2	$500,000 - $1,000,000	$2,677
3	$1,000,001 - $2,500,000	$4,136
4	$2,500,001 - $4,000,000	$5,714

TIER B		
Category	**Your Gross Staff Salaries**	**Your IACP Dues**
5	$4,000,001 - $6,500,000	$7,631
6	$6,500,001 - $8,000,000	$9,850
7	$8,000,001 - $12,500,000	$12,070

TIER C		
Category	**Your Gross Staff Salaries**	**Your IACP Dues**
8	$12,500,001 - $16,000,000	$14,588
9	$16,000,001 - $20,000,000	$16,506
10	$20,000,001 - $25,000,000	$19,062
11	$25,000,001 - $30,000,000	$22,220
12	$30,000,001 - $35,000,000	$24,777
13	$35,000,001 - $40,000,000	$27,333
14	$40,000,001 - $45,000,000	$30,490