



IACP Organization Membership Form

An organization must complete this application form and be approved by the Membership Services committee and IACP 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/Finance Name _____ CFO/Finance Email _____

HR Director Name _____ HR Director Email _____

Procurement Director Name _____ Procurement 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 _____

* 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:

Residential Services

- | | | | |
|---|------------------------------|--|---|
| <input type="checkbox"/> Day Habilitation | <input type="checkbox"/> IPS | <input type="checkbox"/> IVRS | <input type="checkbox"/> Pre-Vocational |
| <input type="checkbox"/> Supported Employment | | <input type="checkbox"/> Work Services | |

Residential Services

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Adult Day Care | <input type="checkbox"/> Assisted Living | <input type="checkbox"/> CDAC | <input type="checkbox"/> CHORE |
| <input type="checkbox"/> CSALA | <input type="checkbox"/> Daily SCL | <input type="checkbox"/> Home-Based Habilitation | <input type="checkbox"/> ICF |
| <input type="checkbox"/> ICF/ID | <input type="checkbox"/> IMMT | <input type="checkbox"/> IRSH | <input type="checkbox"/> Intermittent SCL |
| <input type="checkbox"/> RCF | <input type="checkbox"/> RCF/ID | <input type="checkbox"/> RCF/PMI | <input type="checkbox"/> Residential Treatment |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Shelter Service | | |

Behavioral Health Related Services

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ABA | <input type="checkbox"/> ACT | <input type="checkbox"/> BHIS | <input type="checkbox"/> CCBHC |
| <input type="checkbox"/> CMHC | <input type="checkbox"/> CSS | <input type="checkbox"/> Counseling | <input type="checkbox"/> Crisis Stabilization |
| <input type="checkbox"/> Family and Community Support Services | | <input type="checkbox"/> Family Counseling & Training | |
| <input type="checkbox"/> Habilitation | <input type="checkbox"/> Homeless Outreach | <input type="checkbox"/> IHH | <input type="checkbox"/> IPR |
| <input type="checkbox"/> Medication Mgt | <input type="checkbox"/> Outpatient Services | <input type="checkbox"/> PACE | <input type="checkbox"/> Peer Support |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Substance Use Disorder | <input type="checkbox"/> Transitional Living | |

Children's Services

- | | | | |
|-------------------------------|-----------------------------------|--|---|
| <input type="checkbox"/> BHIS | <input type="checkbox"/> Day Care | <input type="checkbox"/> IMMT | <input type="checkbox"/> Intermittent SCL |
| <input type="checkbox"/> PMIC | <input type="checkbox"/> RB SCL | <input type="checkbox"/> Residential Shelter | <input type="checkbox"/> Respite |

Waiver Services

- | | |
|---|--|
| <input type="checkbox"/> BI Waiver | <input type="checkbox"/> Children's Mental Health Waiver |
| <input type="checkbox"/> Elderly Waiver | <input type="checkbox"/> Health and Disability Waiver |
| <input type="checkbox"/> HIV Waiver | <input type="checkbox"/> ID Waiver |
| <input type="checkbox"/> Physical Disability Waiver | |

Other

- | | |
|---|---|
| <input type="checkbox"/> Child Welfare | <input type="checkbox"/> Community Neurobehavioral Services |
| <input type="checkbox"/> Consumer Choice Option | <input type="checkbox"/> Money Follows the Person |
| <input type="checkbox"/> Outpatient Services (OT,PT, Speech, other) | <input type="checkbox"/> Transportation |



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. The application cannot be processed without this documentation.
- 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)

Paying by Credit Card: VISA MasterCard Discover American Express

Card #: _____ Exp. Date: _____ CVC: _____

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

Credit Card Billing Street Address: _____

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

Cardholder's Signature: _____

Please send completed application to sseehase@iowaproviders.org with documentation of gross staff salaries. An invoice will follow with application fee and dues. Invoice payment can be made with credit card or by mailing a check to IACP, 7025 Hickman Rd, Suite 7, Urbandale, IA 50322.

***Relentlessly advocating for
Iowa providers to build
healthy communities, so
one day, all Iowans will
live, learn and work in their
community of choice.***

IACP Members receive membership with the National Council for Mental Wellbeing and ANCOR. These two national associations representing the national interests of IACP members:

- The National Council for Mental Wellbeing
www.thenationalcouncil.org
- ANCOR – The American Network of Community Options and Resources
www.ancor.org



IACP 2025 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	\$1,663
2	\$500,000 - \$1,000,000	\$2,757
3	\$1,000,001 - \$2,500,000	\$4,260
4	\$2,500,001 - \$4,000,000	\$5,885

TIER B		
Category	Your Gross Staff Salaries	Your IACP Dues
5	\$4,000,001 - \$6,500,000	\$7,860
6	\$6,500,001 - \$8,000,000	\$10,146
7	\$8,000,001 - \$12,500,000	\$12,432

TIER C		
Category	Your Gross Staff Salaries	Your IACP Dues
8	\$12,500,001 - \$16,000,000	\$15,026
9	\$16,000,001 - \$20,000,000	\$17,001
10	\$20,000,001 - \$25,000,000	\$19,634
11	\$25,000,001 - \$30,000,000	\$22,887
12	\$30,000,001 - \$35,000,000	\$25,520
13	\$35,000,001 - \$40,000,000	\$28,153
14	\$40,000,001 - \$45,000,000	\$31,405
15	\$45,000,000 - plus	\$34,389

