VIRGINIA ASSOCIATION OF PERSONAL CARE PROVIDERS
2026 MEMBERSHIP INFORMATION SHEET
(Providers & Associate Members Only)

Company Name:

_____

Address:

_____

Phone Number:

_____

Fax Number:

_____

E-mail Address:

_____

Contact Name:

_____

Owner's Name:

_____

Owner's Phone Number:

_____

Type of Provider: ☐ **Private Duty** ☐ **Medicaid** ☐ **Medicare**

How many years in business? _____

Locations:

_____

Number of Offices: _____

State Licensed: ☐ **Yes** ☐ **No**

Exempt: ☐ **Yes** ☐ **No**

Membership Fee & Payment Information

Amount Paid:

$_____

Membership Fee Options:

- **$800.00 –** Annual membership. The membership year follows the calendar year and begins January 1.
- **$400.00 –** Prorated rate for agencies joining on or after July 1, covering the remainder of the membership year.

Payment Method (please check one):

☐ Check enclosed – **Check Number:** _____

☐ PayPal

If paying via PayPal:

PayPal Payer Name/Email (if different from Company Name):

_____

Submission Instructions

Please mail this form and payment for membership to:

VAPCP c/o ACS West, Inc.
1904 Byrd Avenue, Suite 100
Richmond, VA 23230

OR

Email the completed form to **admin@vapcp.org** and visit **www.vapcp.org/joinus** to pay via PayPal.