



VIRGINIA ASSOCIATION OF PERSONAL CARE PROVIDERS
2027 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

Referred By: _____



Membership Fee & Payment Information

2027 Membership Dues:

\$850.00 – Annual membership (January 1–December 31). Join by December 31, 2026 and save \$50.

Amount Paid:

\$ _____

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.