National Alliance for Care at Home

PD HOME CARE MEMBERSHIP APPLICATION

Organization Name: _____

Primary Location Address: _____

_____

City _____ State _____ Zip: _____

Country _____

Main Phone: _____ Main Fax: _____

Website: _____

CERTIFICATIONS: (enter number where applicable)

Primary Home Care Med Cert ID#: _____ Primary Hospice Med Cert ID#: _____

PRIMARY CONTACT:

Primary Contact: _____ Primary Contact Title: _____

Primary Contact Phone: _____ Primary Contact Email: _____

NAME OF VOTING CONTACT: (if not primary contact)

NOTE: Your Voting Section will be in the PD Home Care section

Voting Contact: _____ Voting Contact Title: _____

Voting Contact Phone: _____ Voting Contact Email: _____

UPDATE YOUR ORGANIZATION'S OVERALL PROFILE WITH US:

Current Number of FTEs: _____

PROVIDER TYPE: (check all that apply)

- ☐ Home Health
- ☐ Hospice
- ☐ Infusion
- ☐ Palliative
- ☐ Private Duty Home Care

ENTITY TYPE: (check all that apply)

- ☐ Institution-based
- ☐ Government-based
- ☐ Freestanding National
- ☐ Integrated Health System Provider
- ☐ For Profit
- ☐ Nonprofit
- ☐ Provider
- ☐ Health System Affiliated (affiliated with a non-home care entity)
- ☐ Rural
- ☐ Urban

SERVICES OFFERED BY ENTIRE ORGANIZATION: (check all that apply)

- ☐ Alzheimer's/Dementia Care
- ☐ Companion Care Services
- ☐ Dietitian Service
- ☐ Homemaking/Household Support
- ☐ Nursing (RN LPN)
- ☐ Live-in Support
- ☐ Occupational Therapy
- ☐ Personal Care Services/ Home Care Aide
- ☐ Physical Therapy
- ☐ Respite
- ☐ Transportation
- ☐ Veteran Care/We Honor Veterans Program
- ☐ Other: _____

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DUES AND PAYMENT:

PD Home Care Membership

PD Home Care Members Dues . . . . . $ **550.00**

OPTIONAL SUBSCRIPTIONS/SERVICES/HHFMA:

(check to Select)

☐ **Journal of Pain and Symptom Management**
One-year subscription $160 (12 issues) $_____

☐ Add **Home Health and Hospice Financial Managers Association (HHFMA)** $150 per individual $_____
Attach list of Names, Titles, and Emails of those you wish to join HHFMA.

GRAND TOTAL OF DUES, SUBSCRIPTIONS, AND HHFMA:

Add all together $_____

4 PAYMENT OPTIONS:

1. **SAVE TIME AND MONEY RENEWING ONLINE**
   www.AllianceForCareAtHome.org
2. **MAIL:**
   ALLIANCE LOCKBOX
   PO Box 37558
   Baltimore, MD 21297-3558
3. **FAX#:**
   703-837-1233
4. **EMAIL:**
   membership@
   AllianceForCareAtHome.org

Please contact us at (800) 646-6460 or membership@AllianceForCareAtHome.org if you have any questions.

PAYMENT TYPE USED:

☐ **CHECK ENCLOSED** Check #:_____

☐ **ACH** – TRUIST Bank,
Routing/Transit #021052053 Account #: 22698819

☐ **CREDIT CARD**
◯ VISA ◯ MASTERCARD ◯ AMERICAN EXPRESS ◯ DISCOVER

_____
Credit Card Number

_____
Expiration Date Billing Zip Code

_____
CVV# (found on back of the card)

_____
Print name as it appears on card

_____
Signature of Cardholder

NOTE: Please include all completed forms when sending payment or when submitting an ACH payment. Incomplete applications result in processing delays. Thank you for your membership in the Alliance!

Association dues payments, to the Alliance or otherwise, are not tax deductible as charitable contributions, Sections 501(c)5 and (c)6. The Internal Revenue Code limits the amount of business expense deductions for dues paid to an association that engages in lobbying activities even if dues are not used for lobbying; the amount excluded is 23% based on IRS criteria. EIN - 84-0617736.

Alliance membership dues are non-refundable.

Please consider making a charitable donation to the National Alliance for Care at Home Foundation: AllianceForCareAtHome.org/foundation.org