CORPORATE APPLICATION

Membership Information:

- *Service Line Member:* Eligible organizations must be engaged in the delivery of home care through certified home care, hospice, private duty home care, home pharmacy/infusion or home medical equipment services. Each legally recognized business unit is eligible for a membership. For purposes of membership, each organization with a filed assumed name is considered a legally recognized business unit. Each service line membership shall have one vote in association elections. Service line members may serve on the Board of Directors, and may hold office.
- Minimum dues is $500 and maximum dues is $12000.
- The membership year is good for one year from date of application.
- If dues are owed from a prior year, payments received will apply to past dues before the renewal dues.
- Renewals are organizations that have been a member in the past 5 years.
- Under the 1993 Tax Act, 15% of Michigan HomeCare & Hospice Association Membership Dues are not tax deductible for federal income tax purposes because they are treated as lobbying expenditures. You may wish to consult your tax advisor of this provision.
- Explanation of Payment: If total dues are $1,000 or less, the full amount must be sent with your membership application. If your dues are more than $1,000, you may request quarterly billing. Payments are due: June 1, September 1, December 1 and March 1. Late payments will be charged 1.5% interest per month.
- Please note that your e-mail is necessary in order for you to receive the *Committee Bulletin Board* and other action alert items that warrant your attention.
- New member applications do have to be approved by our Board of Directors, which meets monthly. Member certificate and packet will be mailed after approval is received.

Please complete the following information for each legally recognized business unit. This information is used to determine your voting privileges, board representation, mailings sent to you, member directory content and dues amount.

Check One: ☐ New Member Application ☐ Renewal Application

How did you hear about us?_____

*Required. Will be listed in Membership Directory

* Corporation Name: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

*Phone: _____ *Fax: _____

*Counties Served: _____

_____

*Send Communications to (contact person): _____

*Contact E-mail: _____

*Administration: _____ E-mail: _____

CFO: _____ E-mail: _____

Chief Clinical Manager: _____ E-mail: _____

Medical Director: _____ E-mail: _____

Other: _____ E-mail:_____

DUES STRUCTURE:

Total Revenue of All Entities	Dues
< $1,000,000	$500
$1,000,001-$2,500,000	$1000
$2,500,001-$3,500,000	$2000
$3,500,001-$4,500,000	$3500
$4,500,001-$5,500,000	$4500
$5,500,001-12,000,000	$6000
$12,000,001-$15,000,000	$8500
$15,000,001-$25,000,000	$10,000
$25,000,001-$50,000,000	$11,000
>$50,000,001	$12,000

List other entities/locations to be included in the corporate membership. Make copies of this page as needed.

* Location Name: _____

*Address: _____

*City: _____ * State: _____ *Zip: _____

*Phone: _____ *Fax: _____

*Counties Served: _____

_____

* Send Communications to (contact person): _____

*Contact E-mail: _____

Voting Member: _____ E-mail: _____

*Certified ☐ * Hospice ☐ * Private Duty/Personal Care ☐
*Home Medical Equipment (HME) ☐ *Infusion Pharmacy ☐

Programs: (Please check all that apply)
☐ Wound (ENT) ☐ Psych ☐ Rehab ☐ Maternal/Child ☐ Infusion ☐Palliative Care ☐Private Pay Medical
☐ Cardiac ☐ Nutrition ☐ Oncology ☐ Waiver ☐ Residential Facility ☐ Certified ☐Personal Care
☐ Peds. ☐ Skilled Service ☐ Staffing ☐ Homemaker ☐ Live-ins ☐ Assisted Living ☐ Personal Response System
☐ Immunization ☐ DME ☐ Infusion ☐ Orthotics/prosthetics ☐ Respiratory ☐ Rehab ☐ Bereavement Services
☐ Chemo ☐ Blood Products ☐ Enteral ☐ Medical Surgical ☐ Other (list): _____

* Please indicate organization type:
☐ Proprietary/For Profit ☐ Health Department ☐ Private/Nonprofit ☐ Hospital Affiliate ☐ Hospital Based
☐ Visiting Nurse Association ☐ Other (list):

* Accreditation:
☐ Joint Commission ☐ CHAP ☐ ACHC ☐ Other: _____

If Medicare Provider, Who is your Fiscal Intermediary? _____

This organization is: ☐ Medicare Certified ☐ Medicaid Certified ☐ Blue Cross Blue Shield Participant
☐ Other: _____

Total Revenue: _____

TOTAL REVENUE FROM ALL ENTITIES (on all pages): _____

Total Dues Enclosed: $ _____

Payment Information:
• Full payment enclosed.
• Bill us quarterly, our total dues exceed $1,000.

Credit Card Payment: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card #: _____ Exp. Date: _____

Signature on Card: _____

I certify that all information contained in this application is correct and valid to the best of my knowledge. I further certify that I have read the Michigan HomeCare & Hospice Association's *Code of Ethics and the Bylaws Article III Membership Insert* and pledge that this organization understands and will adhere to the Code of Ethics. I further certify that I have read the bylaws definition of Service Line Member and verify that my organization qualifies as a Service Line Member. FCC Communication Consent: I understand that by providing my mailing address, e-mail address, telephone number and fax number, I consent to receive communications via regular mail, e-mail, telephone and or fax sent by or on behalf of the Michigan HomeCare & Hospice Association.

Signed: _____

Mail completed application with dues payment: Michigan HomeCare & Hospice Association,
2140 University Park Drive, Suite 220, Okemos, MI 48864 Phone: 517-349-8089 Fax: 517-349-8090