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:

<table>
<thead>
<tr>
<th>Total Revenue of All Entities</th>
<th>Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; $1,000,000</td>
<td>$500</td>
</tr>
<tr>
<td>$1,000,001-$2,500,000</td>
<td>$1000</td>
</tr>
<tr>
<td>$2,500,001-$3,500,000</td>
<td>$2000</td>
</tr>
<tr>
<td>$3,500,001-$4,500,000</td>
<td>$3500</td>
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<tr>
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<td>$6000</td>
</tr>
<tr>
<td>$12,000,001-$15,000,000</td>
<td>$8500</td>
</tr>
<tr>
<td>$15,000,001-$25,000,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>$25,000,001-$50,000,000</td>
<td>$11,000</td>
</tr>
<tr>
<td>&gt;$50,000,001</td>
<td>$12,000</td>
</tr>
</tbody>
</table>
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 □  * Palliative Care □

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