



## Service Line Membership 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 shall be 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 are \$500 and maximum dues are \$5000.
- ◆ 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. This is general information, and before acting upon it, you may wish to consult with your tax advisor.
- ◆ Quarterly Payment Eligibility for new and renewing memberships. 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 are eligible for quarterly billing. Late payments will be charged 1.5% interest per month.
- ◆ **Please note that your e-mail address is necessary to receive the *Committee Bulletin Board* and other action alert items that warrant your attention. Please include your current email address with your new or renewing application.**
- ◆ New member applications do have to be approved by our Board of Directors which meets the 2<sup>nd</sup> Thursday of every month. Membership certificate and packet will be mailed after approval is received.

# Michigan HomeCare & Hospice Association Service Line Membership Application

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**

\*Administrator: \_\_\_\_\_ E-mail: \_\_\_\_\_

CFO: \_\_\_\_\_ E-mail: \_\_\_\_\_

Chief Clinical Manager: \_\_\_\_\_ E-mail: \_\_\_\_\_

Medical Director: \_\_\_\_\_ E-mail: \_\_\_\_\_

\* Organization Name: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \* State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

\*Phone: \_\_\_\_\_ \*Fax: \_\_\_\_\_

\*Counties Served: \_\_\_\_\_

\_\_\_\_\_

\* Send Communications to (contact person): \_\_\_\_\_

\*Contact E-mail: \_\_\_\_\_

Voting Member: \_\_\_\_\_ E-mail: \_\_\_\_\_

**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.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Certified/Hospice Membership Application

\*Will be listed in Membership Directory

Benefits:	Dues Calculation
<ul style="list-style-type: none"> <li>◆ Discounts on registrations at all MHHA workshops and conferences;</li> <li>◆ Networking Opportunities;</li> <li>◆ Discounts on Publications and Videos;</li> <li>◆ Monthly <i>Bulletin Board</i>;</li> <li>◆ CHAP Discounts;</li> <li>◆ ACHC Discounts;</li> <li>◆ Opportunities to join and participate in Michigan HomeCare &amp; Hospice Committees within your selected service line (see organizational chart); and much more!</li> </ul>	
<p><b>*Certified</b> <input type="checkbox"/></p> <p><b>Programs: (Please check all that apply)</b></p> <p> <input type="checkbox"/> Wound (ENT)   <input type="checkbox"/> Psych   <input type="checkbox"/> Rehab   <input type="checkbox"/> Maternal/Child   <input type="checkbox"/> Infusion  <input type="checkbox"/> Cardiac   <input type="checkbox"/> Nutrition   <input type="checkbox"/> Oncology   <input type="checkbox"/> Waiver   <input type="checkbox"/> Peds.   <input type="checkbox"/> Palliative            Care   <input type="checkbox"/> Other (list): _____         </p>	<p><b>Total Revenue for Certified:</b>    \$ _____</p>
<p><b>* Hospice</b> <input type="checkbox"/></p> <p><b>* Programs: (Please check all that apply)</b></p> <p> <input type="checkbox"/> Residential Facility   <input type="checkbox"/> Medicare Certified   <input type="checkbox"/> Bereavement Services  <input type="checkbox"/> Other (list): _____         </p>	<p><b>Total Revenue for Hospice:</b>    \$ _____</p>
<p><b>* Palliative Care</b> <input type="checkbox"/></p>	<p><b>Total Revenue for Palliative Care:</b>    \$ _____</p>
<p><b>* Please indicate organization type:</b>   <input type="checkbox"/> Health Department   <input type="checkbox"/> Private/Nonprofit</p> <p> <input type="checkbox"/> Hospital Affiliate   <input type="checkbox"/> Hospital Based   <input type="checkbox"/> Proprietary/For Profit  <input type="checkbox"/> Visiting Nurse Association   <input type="checkbox"/> Other (list): _____         </p>	<p><b>Total Certified &amp; Hospice Revenue:</b>    \$ _____</p>
<p><b>* Accreditation:</b>   <input type="checkbox"/> Joint Commission   <input type="checkbox"/> CHAP   <input type="checkbox"/> ACHC</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Multiply Total Sales by:</b>    <b>.000714</b></p>
<p><b>Who is your Fiscal Intermediary?</b> _____</p>	<p><b>Total Dues:</b>    \$ _____</p> <p><i>(Minimum dues \$500 and Maximum dues \$5000)</i></p>
<p><b>This organization is:</b>   <input type="checkbox"/> Medicare Certified   <input type="checkbox"/> Medicaid Certified</p> <p style="padding-left: 40px;"><input type="checkbox"/> Blue Cross Blue Shield Participant</p>	<p><b>Branch locations:</b></p> <p>(Attach a separate sheet including contact name, address, phone, fax, programs, etc.)</p>
<p><b>Is this organization tax exempt?</b>    <input type="checkbox"/> Yes                      <input type="checkbox"/> No</p>	<p><b>Total Dues:</b>    \$ _____</p>
<p><b>Payment Information:</b></p> <p><input type="checkbox"/> Full payment enclosed.</p> <p><input type="checkbox"/> Bill us quarterly, our total dues exceed \$1,000.</p>	
<p><b>Credit Card Payment:</b>   <input type="checkbox"/> Visa   <input type="checkbox"/> MasterCard   <input type="checkbox"/> Discover   <input type="checkbox"/> American Express</p> <p>Card #: _____ Exp. Date: _____</p>	
<p>Signature on Card: _____</p>	

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 and 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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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

## Private Duty Membership Application

\*Will be listed in Membership Directory

<p><b>Benefits:</b></p> <ul style="list-style-type: none"><li>◆ Discounts on registrations at all MHHA workshops and conferences;</li><li>◆ Networking Opportunities;</li><li>◆ Discounts on Publications and Videos;</li><li>◆ Monthly <b>Bulletin Board</b>;</li><li>◆ CHAP Discounts;</li><li>◆ ACHC Discounts;</li><li>◆ Opportunities to join and participate in Michigan HomeCare &amp; Hospice Committees within your selected service line (see organizational chart); and much more!</li></ul> <p><b>* Private Duty</b> <input type="checkbox"/></p> <p><b>* Programs: (Please check all that apply)</b></p> <p><input type="checkbox"/> Peds    <input type="checkbox"/> Maternal/Child    <input type="checkbox"/> Skilled Service    <input type="checkbox"/> Staffing</p> <p><input type="checkbox"/> Homemaker    <input type="checkbox"/> Live-ins    <input type="checkbox"/> Assisted Living    <input type="checkbox"/> Personal Response System</p> <p><input type="checkbox"/> Immunization    <input type="checkbox"/> Personal Care    <input type="checkbox"/> Private    <input type="checkbox"/> Pay Medical</p> <p><input type="checkbox"/> Other (list): _____</p> <p><b>* Please indicate organization type:</b>    <input type="checkbox"/> Health Department    <input type="checkbox"/> Private/Nonprofit</p> <p><input type="checkbox"/> Hospital Affiliate    <input type="checkbox"/> Hospital Based    <input type="checkbox"/> Proprietary/For Profit</p> <p><input type="checkbox"/> Visiting Nurse Association    <input type="checkbox"/> Other (list): _____</p> <p><b>* Accreditation:</b>    <input type="checkbox"/> Joint Commission    <input type="checkbox"/> CHAP    <input type="checkbox"/> ACHC</p> <p><input type="checkbox"/> Other: _____</p> <p><b>This organization is:</b>    <input type="checkbox"/> Medicare Certified    <input type="checkbox"/> Medicaid Certified</p> <p style="padding-left: 40px;"><input type="checkbox"/> Blue Cross Blue Shield Participant</p> <p><b>Is this organization tax exempt?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>Payment Information:</b></p> <p><input type="checkbox"/> Full payment enclosed.</p> <p><input type="checkbox"/> Bill us quarterly, our total dues are more than \$1,000.</p> <p><b>Credit Card Payment:</b>    <input type="checkbox"/> Visa    <input type="checkbox"/> MasterCard    <input type="checkbox"/> Discover    <input type="checkbox"/> American Express</p> <p>Card #: _____ Exp. Date: _____</p> <p>Signature on Card: _____</p>	<p style="text-align: center;"><b>Dues Calculation</b></p>  <p><b>Total Revenue for Private Duty:</b>                                      \$ _____</p>         <p><b>Multiply Total Sales by:</b>                                      <b>.000357</b></p> <p><b>Total Dues:</b>                                      \$ _____</p> <p style="color: red;"><i>(Minimum dues \$500 and Maximum dues \$5000)</i></p> <p><b>Branch locations:</b></p> <p>(Attach a separate sheet including contact name, address, phone, fax, programs, etc.)</p>    <p><b>Total Dues:</b>                                      \$ _____</p>
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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 and 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.

Signed \_\_\_\_\_ Date: \_\_\_\_\_

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## HME/Infusion Pharmacy Membership Application

\*Will be listed in Membership Directory

<p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>◆ Discounts on registrations at all MHHA workshops and conferences;</li> <li>◆ Networking Opportunities;</li> <li>◆ Discounts on Publications and Videos;</li> <li>◆ <b>Committee Bulletin Board;</b></li> <li>◆ CHAP Discounts;</li> <li>◆ ACHC Discounts;</li> <li>◆ Opportunities to join and participate in Michigan HomeCare &amp; Hospice Committees within your selected service line (see organizational chart); and much more!</li> </ul> <p><b>*Home Medical Equipment (HME)</b> <input type="checkbox"/></p> <p><b>* Programs: (Please check all that apply)</b></p> <p><input type="checkbox"/> DME    <input type="checkbox"/> Enteral    <input type="checkbox"/> Infusion    <input type="checkbox"/> Orthotics/prosthetics    <input type="checkbox"/> Respiratory</p> <p><input type="checkbox"/> Rehab    <input type="checkbox"/> Medical Surgical    <input type="checkbox"/> Other (list): _____</p> <p><b>* Infusion Pharmacy</b> <input type="checkbox"/></p> <p><b>* Programs: (Please check all that apply)</b></p> <p><input type="checkbox"/> Chemo    <input type="checkbox"/> Blood Products    <input type="checkbox"/> Enteral    <input type="checkbox"/> Other (list): _____</p> <p><b>* Please indicate organization type:</b>    <input type="checkbox"/> Health Department    <input type="checkbox"/> Private/Nonprofit</p> <p><input type="checkbox"/> Hospital Affiliate    <input type="checkbox"/> Hospital Based    <input type="checkbox"/> Proprietary/For Profit</p> <p><input type="checkbox"/> Visiting Nurse Association    <input type="checkbox"/> Other (list): _____</p> <p><b>* Accreditation:</b>    <input type="checkbox"/> Joint Commission    <input type="checkbox"/> CHAP    <input type="checkbox"/> ACHC</p> <p><input type="checkbox"/> Other: _____</p> <p><b>Who is your Fiscal Intermediary?</b> _____</p> <p><b>This organization is:</b>    <input type="checkbox"/> Medicare Certified    <input type="checkbox"/> Medicaid Certified</p> <p style="padding-left: 40px;"><input type="checkbox"/> Blue Cross Blue Shield Participant</p> <p><b>Is this organization tax exempt?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>Payment Information:</b></p> <p><input type="checkbox"/> Full payment enclosed.</p> <p><input type="checkbox"/> Bill us quarterly, our total dues are more than \$1,000.</p> <p><b>Credit Card Payment:</b>    <input type="checkbox"/> Visa    <input type="checkbox"/> MasterCard    <input type="checkbox"/> Discover    <input type="checkbox"/> American Express</p> <p>Card #: _____ Exp. Date: _____</p> <p>Signature on Card: _____</p>	<p style="text-align: center;"><b>Dues Calculation</b></p> <p><b>Total Sales for HME:</b>                    \$ _____</p> <p><b>Total Sales for Infusion:</b>                    \$ _____</p> <p><b>Total HME &amp; Infusion Sales:</b>                    \$ _____</p> <p><b>Multiply Total Sales by:</b>                    <b>.000357</b></p> <p><b>Total Dues:</b>                    \$ _____</p> <p style="color: red;"><i>(Minimum dues \$500 and Maximum dues \$5000)</i></p> <p><b>Branch locations:</b></p> <p>(Attach a separate sheet including contact name, address, phone, fax, programs, etc.)</p> <p><b>Total Dues:</b>                    \$ _____</p>
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Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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