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, 16% 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-mailaddress 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 2nd Thursday of every month. Membership certificate and packet will be mailed after approval is received.

Benefits:

- Discounts on registrations at all MHHA workshops and conferences;
- Networking Opportunities;
- Discounts on Publications and Videos;
- Monthly ***Bulletin Board***;
- CHAP Discounts;
- ACHC Discounts;
- Opportunities to join and participate in Michigan HomeCare & Hospice Committees within your selected service line (see organizational chart); and much more!

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: _____

Over ➔

Certified/Hospice Membership Application

*Will be listed in Membership Directory

***Certified** ❑

Programs: (Please check all that apply)

❑Skilled Nursing ❑ Wound/Ostomy ❑ Psych ❑ Rehab ❑ Maternal/Child
❑ Infusion ❑ Cardiac ❑ Oncology ❑ Pediatrics. ❑Palliative Care ❑Speech Therapy ❑Occupational Therapy ❑ Physical Therapy ❑Big and Loud Therapy
❑Brain/neuro Rehab ❑Spinal Rehab ❑Transportation ❑Dietician/Nutrition
❑Transitional Care ❑Home Care Aides ❑ Telehealth ❑Mobile Diagnostics
❑Alzheimer's Care ❑Diabetic ❑Social Work
❑ Other (list): _____

Total Revenue for Certified: $_____

* **Hospice** ❑

*** Programs: (Please check all that apply)**

❑ Residential Facility ❑ Music Therapy ❑Massage Therapy ❑Pet Therapy
❑ Bereavement Services ❑Respite ❑Transitional Care ❑Transportation
❑Dietician/Nutrition ❑We Honor Vets
❑ Other (list): _____

Total Revenue for Hospice: $_____

* **Palliative Care** ❑

❑Transitional Care ❑Respite ❑Home—based ❑Facility-based
❑ Hospital Consultations ❑Outpatient Clinic

Total Revenue for Palliative Care: $_____

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

Total Certified & Hospice & Palliative Care Revenue: $_____

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

Multiply Total Sales by: .000714

Total Dues: $_____
(Minimum dues $500 and Maximum dues $5000)

Who is your Fiscal Intermediary? _____

This organization is: ❑ Medicare Certified ❑ Medicaid Certified
❑ Blue Cross Blue Shield Participant ❑Other Insurances

Branch locations:
(Attach a separate sheet including contact name, address, phone, fax, programs, etc.)

Is this organization tax exempt? ❑ **Yes** ❑ **No**

Total Dues: $_____

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 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

*** Private Duty** ❑

*** Programs: (Please check all that apply)**

❑Peds ❑Maternal/Child ❑ Skilled Nursing ❑ Staffing
❑ Homemaker ❑ Live-in ❑ Assisted Living
❑ Immunization ❑ Personal Care ❑Private Pay Medical ❑Spinal Rehab
❑ Brain Rehab ❑Home Care Aides ❑Transitional Care ❑Respite ❑Dietician
❑Transportation ❑Adult Day Care ❑Alzheimer's Care
❑ Other (list): _____

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

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

This organization is: ❑Private Pay Medical ❑ Medicaid Certified
❑VA Participant ❑ Blue Cross Blue Shield Participant ❑ Medicaid Waiver
❑Other Insurances

Is this organization tax exempt? ❑ **Yes** ❑ **No**

Payment Information:
❑ Full payment enclosed.
❑ Bill us quarterly, our total dues are more than $1,000.

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

Card #:_____ Exp. Date:_____

Signature on Card: _____

Dues Calculation

Total Revenue for Private Duty: **$**_____

Multiply Total Sales by: **.000357**

Total Dues: **$**_____
(Minimum dues $500 and Maximum dues $5000)

Branch locations:
(Attach a separate sheet including contact name, address, phone, fax, programs, etc.)

Total Dues: $_____

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

***Home Medical Equipment (HME)** ❑

*** Programs: (Please check all that apply)**

❑ DME ❑Enteral ❑ Infusion ❑ Orthotics/prosthetics ❑ Respiratory ❑ Rehab ❑ Medical Surgical ❑Complex Rehab Technology (CRT) ❑Medical Supplies ❑Mobility ❑Sleep Therapy ❑ Other (list): _____

*** Infusion Pharmacy** ❑

*** Programs: (Please check all that apply)**

❑ Chemo ❑ Blood Products ❑ Enteral ❑ Other (list): _____

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

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

Who is your Fiscal Intermediary? _____

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

Is this organization tax exempt? ❑ **Yes** ❑ **No**

Payment Information:

❑ Full payment enclosed.

❑ Bill us quarterly, our total dues are more than $1,000.

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

Card #:_____ Exp. Date: _____

Signature on Card: _____

Dues Calculation

Total Sales for HME: **$**_____

Total Sales for Infusion: **$**_____

Total HME & Infusion Sales: $_____

Multiply Total Sales by: **.000357**

Total Dues: **$**_____

(Minimum dues $500 and Maximum dues $5000)

Branch locations:

(Attach a separate sheet including contact name, address, phone, fax, programs, etc.)

Total Dues: $_____

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