National Alliance for Care at Home

BUSINESS PARTNER MEMBERSHIP APPLICATION

Organization Name: _____

Primary Location Address: _____

_____

City _____ State _____ Zip: _____

Country _____

Main Phone: _____ Main Fax: _____

Website: _____

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 Business Partner section

Voting Contact: _____ Voting Contact Title: _____

Voting Contact Phone: _____ Voting Contact Email: _____

UPDATE YOUR ORGANIZATION'S OVERALL PROFILE WITH US:

Current Number of FTEs: _____

LINE OF BUSINESS: (check all that apply)

- ☐ Accountable Care Organization
- ☐ Accreditation
- ☐ Assisted Living
- ☐ Advance Care Planning Service
- ☐ Communications Technology
- ☐ Companion Service
- ☐ Computer Software
- ☐ Computer Hardware
- ☐ Consultant/Consulting
- ☐ Data Analytics / Data Analytics Benchmarking Software
- ☐ Durable Medical Equipment / Home Medical Equipment
- ☐ Education & Training
- ☐ Electronic Medical Records Providers
- ☐ End of Life Care
- ☐ Financial Services
- ☐ Funeral Home
- ☐ Grief & Bereavement
- ☐ Health Insurance Plan
- ☐ Home Care Business Services
- ☐ Insurance/ Risk Management
- ☐ Integrative & Rehabilitation Therapies
- ☐ International Organization
- ☐ Legal Services
- ☐ Media & Marketing
- ☐ Medical Billing and Coding
- ☐ Medical Equipment and Supplies / Medical Devices
- ☐ National/International Association
- ☐ Office/Business Products
- ☐ Pharmacy Management Services
- ☐ Pharmaceutical
- ☐ Physical Therapy
- ☐ Research and Education
- ☐ Publisher
- ☐ Recruitment/Staffing
- ☐ Religious Organization
- ☐ Remote Patient Monitoring
- ☐ Research and Education
- ☐ Software Vendor
- ☐ University/College/Academia
- ☐ Telehealth / Telehealth Software
- ☐ Other: _____

_____

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BUSINESS PARTNER DUES CHART

Gross Industry Revenue Range	Dues
$0 – $200,000	$1,000
$200,001 – $500,000	$2,000
$500,001 – $1,000,000	$3,000
$1,000,001 – $5,000,000	$4,000
$5,000,001 – $10,000,000	$5,000
$10,000,001 – $15,000,000	$6,000
$15,000,001 – $20,000,000	$7,000
$20,000,001 – $25,000,000	$8,000
$25,000,001 – $50,000,000	$9,000
$50,000,001 – $75,000,000	$10,000
$75,000,001 – $100,000,000	$11,000
$100,000,001+	$12,000

Total Revenue:_____ Initials_____

Business Partner members receive one complimentary membership in the Home Care & Hospice Financial Managers Association (HHFMA). Additional HHFMA memberships are available at $150 per individual (see next page to add names.)

Principal HHFMA contact

Name: _____

Email: _____

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.

MEMBERSHIP DUES CALCULATION:

Please use the chart to the left to determine dues based on Gross Revenue. The company's total gross revenue attributable to business related to care in the home only.

DUES: $_____

OPTIONAL SUBSCRIPTIONS/SERVICES/HHFMA:

(check to Select)

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

☐ Add **Home Care 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 $_____

SELECT IF PAYING IN FULL OR IN INSTALLMENTS: (please select one)

☐ **Payment in full** $_____

☐ **Semi-annual Payments** $_____
First payment is due with this application then six months from start of membership term second payment is due. (Example: if paying for Jan 1, your second payment is due July 1)

☐ **Quarterly Payments:** $_____
First payment is due with this application then pay the next 3 installments in 3 month increments after start of membership term (Example: if the membership term starts Jan 1, the second is due April 1, third payment July 1, last payment October 1)

NOTE: If paying in installments, the first installment must include ½ or ¼ dues plus fees for additional subscriptions, services, and HHFMA. If paying by credit card you have the option to pay by autopay on your installment due dates.

☐ **Check box to agree to have card charged via autopay on due dates.**

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 currently 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