



# Indiana Association for Home & Hospice Care 2010 Associate Vendor Membership Application

**Associate Vendor Membership:** A business that supplies goods and/or services for compensation to home care, personal service and hospice agencies, or their patients, but does not supply in-home personnel. Associate Vendor Members shall not have voting rights, shall not hold office or serve as an officer or Director of the Corporation nor chair any standing committee of the Corporation.

**Associate Vendor Membership Benefits:**

- Free banner advertisement on the IAHC website.
- Contact information sent to all IAHC Voting Members on a quarterly basis.
- Listed on the Associate Member page of IAHC's website. Includes a search feature for members looking for goods/services.
- Opportunity to advertise and submit educational articles for *The Communiqué*, IAHC's newsletter, that relate to services provided and/or area of expertise.
- Opportunity to attend member committee meetings.
- Reduced exhibitor rates for the **Annual Conference & Trade Show**, May 11-12, 2010, to be held at the Marriott East Hotel & Conference Center, Indianapolis.

**Step One: Company Information**

**Contact Person** (Person designated to receive mailings): \_\_\_\_\_

**Provider/Company Name:** \_\_\_\_\_

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

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

**Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_\_) \_\_\_\_\_

**Toll Free Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Individual E-Mail:** \_\_\_\_\_

**Company E-Mail:** \_\_\_\_\_ **Website:** \_\_\_\_\_

**Please check the type of products/services available to home health agencies:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Accounting              | <input type="checkbox"/> Insurance                                  | <input type="checkbox"/> Pharmaceuticals              |
| <input type="checkbox"/> Advertising Specialties | <input type="checkbox"/> Information Technology/Information Systems | <input type="checkbox"/> Printing & Forms             |
| <input type="checkbox"/> Billing Services        | <input type="checkbox"/> IV Support/Infusion                        | <input type="checkbox"/> Risk Management              |
| <input type="checkbox"/> Clinical Laboratory     | <input type="checkbox"/> Legal                                      | <input type="checkbox"/> Software & Support           |
| <input type="checkbox"/> Collections/Recovery    | <input type="checkbox"/> Medical Supplies & Equipment               | <input type="checkbox"/> Staff Development & Training |
| <input type="checkbox"/> Compliance Programs     | <input type="checkbox"/> Medical Social Services                    | <input type="checkbox"/> Staff Leasing                |
| <input type="checkbox"/> Consulting*             | <input type="checkbox"/> OASIS/Clinical Pathways                    | <input type="checkbox"/> Therapy Services             |
| <input type="checkbox"/> Employee Benefits       | <input type="checkbox"/> Pediatric Products                         |   |
| <input type="checkbox"/> Other _____             |   |   |

**\*Note:** If a consulting firm, please check what type of consulting service(s) your company provides:

- |  |                                     |                                    |   |   |
|--|-------------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Accreditation | <input type="checkbox"/> Clinical   | <input type="checkbox"/> Financial | <input type="checkbox"/> Information Technology/Information Systems |   |
| <input type="checkbox"/> Billing       | <input type="checkbox"/> Compliance | <input type="checkbox"/> Hospice   | <input type="checkbox"/> Management                                 | <input type="checkbox"/> Mergers & Acquisitions |
| <input type="checkbox"/> Other _____   |                                     |                                    |   |   |

**Step Two: Electronic version of the Communiqué**

Your company can now receive the **Communiqué** electronically and save time and money! The electronic version of the **Communiqué** can be delivered to as many of your staff as you request. Please fill in the name and email address of the person(s) who would like to receive the **Communiqué** via email. If you need additional space please send on a separate sheet.

Name \_\_\_\_\_ E-Mail \_\_\_\_\_

Name \_\_\_\_\_ E-Mail \_\_\_\_\_

Name \_\_\_\_\_ E-Mail \_\_\_\_\_

Name \_\_\_\_\_ E-Mail \_\_\_\_\_

Name \_\_\_\_\_ E-Mail \_\_\_\_\_

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**Step Three: Dues Amount**

Associate Vendor ..... \$ 550

**Note:** Contributions to IAHC are not deductible as charitable contributions for federal income tax purposes. However, 88% of your dues payment is deductible as an ordinary and necessary business expense. The Omnibus Reconciliation Act of 1993 provided that a taxpayer would no longer be able to deduct lobbying expenses. For IAHC members, this means that the portion of dues directed to lobbying expenses is not deductible by the member/taxpayer. For 2010, we estimate this to be 12% of your dues payment.

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**Step Four: Sign and Submit Application****Signature Required**

By this signature, I verify that the information provided on this application form is, to the best of my knowledge, correct. I understand that the membership benefits that we receive are only to be used by the company/provider listed in Step One and its employees. Furthermore, I understand that these benefits may not be transferred to another licensed agency or business, which does not hold membership in this association. Any misuse of membership rights and benefits may result in the termination of our membership. I am aware that information on contacting my company will be available for viewing by the public on the IAHC website.

**FCC Communication Consent:** I understand that by providing my mailing address, email address, telephone number, and fax number, I consent to receive communications via regular mail, email, telephone, and/or fax sent by or on behalf of Indiana Association for Home & Hospice Care (IAHC).

\_\_\_\_\_  
Administrator or Contact Person\_\_\_\_\_  
Date

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**Step Five: Payment Information****Payment Summary**

- 2010 Membership Dues from Step Three above \$ 550
- Optional:** I would like to make a contribution to the Hoosiers Helping Home & Hospice Care PAC for Political Action & Public Education: \$ 50

TOTAL AMOUNT DUE \$         **Method of Payment:**

- Check (Made payable to IAHC)
- Visa
- MasterCard

Credit Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_ Security Code: \_\_\_\_\_

Card Holder's Signature: \_\_\_\_\_

**Send completed application with check payable to:** IAHC  
6320-G Rucker Road  
Indianapolis, IN 46220

**Fax completed application with credit card payment to:** (317) 575-8751

**Register & pay on-line at:** [www.iahhc.org](http://www.iahhc.org)

If you have questions regarding Associate Vendor Membership, please contact the IAHC Office at (317) 844-6630.

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**For Office Use ONLY**

Welcome Packet Sent: \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_

**Paid in Full**

Date Paid \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_ Check Number \_\_\_\_\_

Amount Paid \$ \_\_\_\_\_ CC Authorization \_\_\_\_\_

Profile Update: What? \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_ By: \_\_\_\_\_