



Indiana Association for Home & Hospice Care 2019 Associate Affiliate Membership Application

Associate Affiliate Membership:

An Associate Affiliate Member is an entity that does not supply in-home personnel and does not supply goods or services for compensation to home care agencies, hospices, or their patients, but is interested in home care. This category includes a non-profit association or community organization. Affiliate 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 Affiliate Membership Benefits:

- Receive a reduced rate to exhibit at the 2019 Annual Conference, **The IAHHC Annual**, to be held at the [Embassy Suites by Hilton Plainfield Indianapolis Airport](#) on May 8th and 9th.
- Submit your company logo to be featured in rotation on IAHHC's website, www.iahhc.org.
- Receive a listing in the Associate Member directory on the IAHHC website (for members looking for goods/services) as well as in the printed version mailed to each new and renewing IAHHC member.
- Receive a complimentary listing in the in the **Home Care & Hospice Guide**, the printed member directory published annually. Associate Members are also allowed to advertise in the guide.
- Purchase ads and submit articles for the **iWeekly**, IAHHC's weekly e-newsletter.
- Access the IAHHC member mailing list.
- Participate in IAHHC committees alongside agency members.

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 Work Email:** _____

Company E-Mail: _____ **Website:** _____

Step Two: Electronic Version of the iWeekly

Your company can now receive the **iWeekly** electronically and save time and money! The electronic version of the **iWeekly** 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 **iWeekly** 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 _____

Step Three: Dues Amount

Associate Affiliate Membership

\$420

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 2019, we estimate this to be 12% of your dues payment.

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

Step Five: Payment Information

Payment Summary

TOTAL AMOUNT DUE \$ 420

Method of Payment

- Check (Made payable to IAHC)
 Visa MasterCard

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: ____ / ____ Security Code: _____

Card Holder's Signature: _____

Send completed application and check payable to:

IAHC
6320-G Rucker Road
Indianapolis, IN 46220

Fax completed application with credit card payment to:

(317) 775-6674

Register & pay on-line at: www.iahhc.org

If you have questions regarding Associate Affiliate Membership, please contact the IAHC Office at (317) 775-6675.

For Office Use ONLY

Date Paid ____ / ____ / 20____ Check Number _____

Amount Paid \$ _____ CC Receipt _____