



Associate Membership

An Associate Member is 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 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 Membership Levels:

- Standard Associate Membership \$ 750
Classic Associate Membership \$2250
Premium Associate Membership \$5500

Please review the enclosed letter for eligible benefits under each membership level.

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 Info Email: Website:

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

- Accounting Insurance Patient Charting Equipment
Advertising Specialties IV Support/Infusion Pediatric Products
Billing Services Legal Pharmaceuticals
Clinical Laboratory Medical Bill Review Printing & Forms
Collections/Recovery Medical Social Services Risk Management
Compliance Programs Medical Supplies & Equipment Software & Support
Consulting* OASIS/Clinical Pathways Staff Development & Training
Employee Benefits Palliative Care Staff Leasing
Information Technology/Information Systems Therapy Services
Other

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

- Accreditation Compliance Hospice Legal Mergers & Acquisitions
Billing Financial Info Tech/Info Systems Management Telehealth
Clinical Other

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

Step Three: Dues Amount

- | | |
|--------------------------------------------------------|--------|
| <input type="checkbox"/> Standard Associate Membership | \$ 750 |
| <input type="checkbox"/> Classic Associate Membership | \$2250 |
| <input type="checkbox"/> Premium Associate Membership | \$5500 |

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 2024, 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 MUST Accompany Application*)

Payment Summary

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| <input type="checkbox"/> 2024 Membership Dues from Step Three above | \$ _____ |
| <input type="checkbox"/> Optional: I would like to make a contribution to the <i>Hoosiers Helping Home & Hospice Care PAC</i> for Political Action & Public Education | \$ <u> 50 </u> |
| TOTAL AMOUNT DUE | \$ <u> </u> |

Method of Payment

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

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: ____ / ____ Security Code: _____

Card Holder's Signature: _____

Card Holer's Billing Address: _____

Send completed application with 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 Membership, please contact the IAHC Office at (317) 775-6675.

For IAHC Use Only

Date Paid ____ / ____ / 20____ Check Number _____

Amount Paid \$ _____ CC Authorization _____



Indiana Association for Home & Hospice Care Associate Membership Levels

Membership Benefits	Standard Associate	Classic Associate	Premium Associate
Included in all ongoing member education and communication	X	X	X
Free consultation	X	X	X
Access to RCTC	X	X	X
Logo on website	X	X	X
Printed & online search/member directory	X	X	X
Free listing in the <i>Home Care & Hospice Guide</i>	X	X	X
Access to member list	X	X	X
Participate in committees	X	X	X
Purchase ads & article in newsletters	X	X	X
Reduced iWeekly ad rates	X	X	X
Reduced rate at conference	X	X	X
Credit towards conference sponsorship	X	X	X
Logo recognition on the IAHHC Annual Conference Program	X	X	X
Logo recognition on the IAHHC Annual Conference signage	X	X	X
Logo recognition on signage in IAHHC Large Conference Room	X	X	X
Enhanced listing in online member directory	X	X	X
Participate in Webinars	X	X	X
Sponsorship of a 1-day class	X	X	X
Sponsorship of a 2-day class	X	X	X
Provide a 15-minute presentation to the IAHHC Board of Directors	X	X	X
Access to member email list*	X	X	X
Membership Dues	\$750	\$2,250	\$5,500

* Premium Associate Members have the opportunity to receive a complete IAHHC Member Email List for an additional \$1,000 annual fee.