



IHCA Membership Application

E-mail address:	
First Name:	
Last Name:	
Title:	
Company: *	
Provider type(s):	<input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Home Care
Mailing Address 1:	
Address 2:	
City:	
State:	Idaho
Zip Code:	
Phone number:	
Website:	
Cc mail:	
Provider type/membership dues:	<input type="radio"/> Home Health / Hospice / Home Care: \$2500 <input type="radio"/> Home Health / Home Care: \$1500 <input type="radio"/> Home Health / Hospice: \$2000 <input type="radio"/> Home Health only: \$1000 <input type="radio"/> Hospice only: \$1000 <input type="radio"/> Home Care only: \$500
	IHCA Bylaws state: If an agency provides Hospice, Home Health and/or Home Care they must pay dues for all, or none can participate.
Join IHCA for the remainder of 2019 (dues discounted 80%)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2020 dues	<input type="checkbox"/> Yes <input type="checkbox"/> No
PAC Donation: (\$250 donation suggested)	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Form of payment:	<p style="text-align: center;"> <input type="checkbox"/> Check Enclosed <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Amer Expr <input type="checkbox"/> Discover </p> <p>Card Number: <input style="width: 200px; height: 20px; border: 1px solid black;" type="text"/></p> <p>Expires: _____ / _____ (mm/yy) _____ CSV</p> <p>Billing Street Address: _____ Billing Zip Code: _____</p> <p>Authorized Signature: _____</p> <p>Name on Card: _____</p>
Office Use Only	<p><input type="checkbox"/> Organizational profile established</p> <p><input type="checkbox"/> Username: _____</p> <p><input type="checkbox"/> Invoice sent date: _____</p>

***** If applying for membership for more than one [1] provider type, please provide business name & mailing address (if different from above) for each:

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Provider type:	<input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Home Care
Mailing Address 1:	
Address 2:	
City:	
State:	Idaho
Zip Code:	
Phone number:	
Website:	
Company: *	
Provider type:	<input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Home Care
Mailing Address 1:	
Address 2:	
City:	
State:	Idaho
Zip Code:	
Phone number:	
Website:	