IHCA Membership Application

E-mail address:	
First Name:	
Last Name:	
Title:	
Company: *	
Provider type(s):	[ ] Home Health [ ] Hospice [ ] Home Care
Mailing Address 1:	
Address 2:	
City:	
State:	Idaho
Zip Code:	
Phone number:	
Website:	
Cc mail:	
Provider type/membership dues:	○ Home Health / Hospice / Home Care: $2500 ○ Home Health / Home Care: $1500 ○ Home Health / Hospice: $2000 ○ Home Health only: $1000 ○ Hospice only: $1000 ○ 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.
First time IHCA member (dues discounted 50%)	[ ] Yes [ ] No
2022 dues	[ ] Yes [ ] No
PAC Donation: ($250 donation suggested)	[ ] Yes [ ] No

Send to: IHCA ~ 13945 W. Wainwright Drive, Suite 101 ~ Boise ~ ID ~ 83713 or tammie@idhca.org

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Form of payment:	[ ] Check Enclosed [ ] Visa [ ] MasterCard [ ] Amer Expr [ ] Discover Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expires:_____/_____ (mm/yy) _____ CSV Billing Street Address: _____Billing Zip Code: _____ Authorized Signature:_____ Name on Card:_____
Office Use Only	☐ Organizational profile established ☐ Username: ☐ Invoice sent date: _____

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

Company: *	
Provider type:	[ ] Home Health [ ] Hospice [ ] Home Care
Mailing Address 1:	
Address 2:	
City:	
State:	Idaho
Zip Code:	
Phone number:	
Website:	
Company: *	
Provider type:	[ ] Home Health [ ] Hospice [ ] Home Care
Mailing Address 1:	
Address 2:	
City:	
State:	Idaho
Zip Code:	
Phone number:	
Website:	

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