



## 2012 Industry Partner Membership Application

Eligible organizations are those that provide services or products to the home care and/or hospice industry, but are not licensed as a home health agency, hospice, or health care service firm. Examples include: consultants, DME and supply companies, certified public accountants, law firms, skilled nursing facilities, hospitals, etc.

Please Print or Type

### PRIMARY CONTACT

Company Name: \_\_\_\_\_

Main Contact: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Website: \_\_\_\_\_

License: (if applicable) \_\_\_\_\_ Accreditation: (if applicable) \_\_\_\_\_

### ADDITIONAL EMPLOYEES (For Email Network and Other Communications)

Name/ Title: \_\_\_\_\_ Email: \_\_\_\_\_

Name/ Title: \_\_\_\_\_ Email: \_\_\_\_\_

Name/ Title: \_\_\_\_\_ Email: \_\_\_\_\_

### SERVICES OFFERED (Check all that apply)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Accounting         | <input type="checkbox"/> Auditing        | <input type="checkbox"/> DME/ supplies            | <input type="checkbox"/> Technology/website  |
| <input type="checkbox"/> Accreditation      | <input type="checkbox"/> Billing         | <input type="checkbox"/> Recruitment              | <input type="checkbox"/> Telehealth          |
| <input type="checkbox"/> Advertising        | <input type="checkbox"/> Consulting      | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Telephony           |
| <input type="checkbox"/> Answering services | <input type="checkbox"/> Finance/general | <input type="checkbox"/> Technology/software      | <input type="checkbox"/> Transportation      |
| <input type="checkbox"/> Assisted living    | <input type="checkbox"/> Legal           | <input type="checkbox"/> Technology/support       | <input type="checkbox"/> Other (please list) |

Please attach a brief description of company products/services/programs (up to 75 words).

This description will assist the Home Care Association of NJ to provide accurate information about your company.

**PAYMENT AGREEMENT-** *Application must be signed and dated*

Contributions or gifts to the Home Care Association of NJ are not deductible as charitable contributions for Federal income tax purposes. However, dues payments are deductible by members as an ordinary and necessary business expense except for the percentage of dues used for lobbying by the Home Care Association of NJ. The non-deductible percentage of dues is estimated to be approximately 13%.

In accordance with the FCC Regulations, I give the Home Care Association of NJ permission to fax and/or email me or my organization/company, in order to provide me with the information on future Home Care Association of NJ events, services or other activities.

**I understand that our organization/corporation is expected to honor this membership commitment through the end of the dues calendar year and our organization/corporation agrees to pay the full dues amount of \$775.00 to the Home Care Association of New Jersey. No refund of any portion of membership dues for an applicable year shall be made to any member upon resignation or termination of membership.**

I hereby certify, to the best of my knowledge and belief, that the information contained in this Membership Application is true and accurate. I agree to be bound by the terms and conditions of membership, including but not limited to the terms of this payment agreement.

**Authorized Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Membership dues for calendar year 2012 (1/1/2012- 12/31/2012) = \$775.00**

**Payment:**

**Total Amount Due:** \$ 775.00

**Check Number:** \_\_\_\_\_

**Credit Card:**     Visa                       MasterCard                       American Express

**Credit Card Number:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **CVV#** \_\_\_\_\_

**Address on card:** \_\_\_\_\_

**Name on Card:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

***Return application, payment, and Statement of Ethical Values to:***

*Donna Weiss, Director of Operations and Finance, Home Care Association of NJ at  
485D Route 1 South Suite 210, Iselin, NJ 08830 or fax to (732) 877-1101.*



# Statement of Ethical Values

The Home Care Association of New Jersey represents home health agencies, hospices, and health care service firms. The Association promotes accessible, high quality skilled and supportive services that are delivered to people in their places of residence throughout NJ. The mission of the Association is to serve as the catalyst for excellence in home care & hospice.

The Home Care Association of NJ seeks to promote an ethical corporate culture amongst its members so that internal and external relationships are grounded in the fundamental ethical values of autonomy, beneficence, non-maleficence and justice.

**Our members’ policies should reflect these significant ethical values:**

- Respect
- Dignity
- Quality
- Impartiality
- Honesty
- Integrity
- Trust
- Accountability
- Responsibility
- Reliability
- Confidentiality
- Teamwork
- Professionalism
- Loyalty

The Home Care Association of NJ recognizes that situations do and will arise when ethical values conflict. The Home Care Association of NJ expects that each member organization has a process in place to deal with situations arising from such conflicts.

**It should be further noted that the bylaws of the Home Care Association of NJ require:**

For those cases where a member has been found guilty of fraudulent or abusive practice in an administrative agency or court of law, and/or whose license has been revoked or suspended for more than 30 days for fraud & abuse, and has not been approved for reinstatement to provide home care, hospice or other services, membership status will be immediately terminated upon the receipt of formal documentation. The organization will be obligated to pay any outstanding dues in accordance with the Association’s Membership Dues Policy.

**I have received and read the above Statement of Ethical Values:**

Authorized Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Organization: \_\_\_\_\_

***This page must be signed and returned with membership application***

### Did You Remember To?

#### **ALL MEMBERS:**

- Sign and Date the Application.
- Sign and Date the *Statement of Ethical Values page*.
- Enclose payment.

#### **ADDITIONAL REQUIREMENTS FOR PROVIDER MEMBERS:**

- Attach copies of all licenses listed on page 1 of the application.
- Select dues level on page 3 of the application (be sure to include revenue for all licenses listed on page 1).
- Attach proof of revenue level per instructions on page 3 of the application.
- Select payment schedule.

If you have any questions regarding the membership application or any of the required documents please contact Donna Weiss, Director of Operations & Finance at [donna@homecarenj.org](mailto:donna@homecarenj.org) or (732) 877-1100.

**All information must be completed and submitted  
to process membership application**