

**HOME CARE ASSOCIATION OF NEW JERSEY
2010 MEMBERSHIP APPLICATION
ALLIED HEALTH**

Facilities that are licensed or approved by the NJ Department of Health and Senior Services and that do not offer home care and/or hospices. These may include Assisted Living, CCRCs, Skilled Nursing Facilities, Pediatric and Adult Day Care Facilities and Hospitals.

PLEASE PRINT OR TYPE

PRIMARY CONTACT

Company Name _____

Contact Person _____

Title _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-Mail Address _____ Website _____

License (If Applicable) _____ Accreditation (If Applicable) _____

ADDITIONAL EMPLOYEES- For Listserv & Other Communication

Name/Title _____ Email _____

Name/Title _____ Email _____

LICENSE INFORMATION

Facility Type	License Number
Assisted Living	
CCRC	
Skilled Nursing Facility	
Hospital	
Adult/Pediatric Day Care	
Other	

FACILITY DATA

Total Number of: Nurses _____ PT _____ OT _____ ST _____

SW _____ CNA _____ CHHA _____

Total Number of Employees (Admin & Clinical): _____

Patient Census 2009 _____

PAYMENT AGREEMENT

Contributions or gifts to the Home Care Association of NJ are not deductible as a charitable contribution for Federal income tax purposes. Dues payments are deductible by members as a business expense. The percentage of dues (approximately 10%) used for lobbying by the Home Care Association of NJ is not deductible as a business expense.

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 \$1,000.00 to the Home Care Association of New Jersey.

Authorized Signature

Date

Membership Dues for Calendar Year 2010 (1/1/2010-12/31/2010) = \$1,000.00

CHECK CHECK NUMBER _____

VISA MASTERCARD AMERICAN EXPRESS

CREDIT CARD NUMBER _____

Expiration Date _____ CCV # _____

Name of Cardholder _____

Address of Cardholder _____

Signature of Cardholder _____

**Please return application, payment, and statement of Ethical Values Page information to:
Home Care Association of NJ
485D Route 1 South, Suite 210, Iselin, NJ 08830
Attn: Donna Weiss**

Phone: 732-877-1100 Fax: 732-877-1101