HOME CARE ASSOCIATION OF NEW JERSEY
2010 ANCILLARY MEMBERSHIP APPLICATION

Agencies that are not licensed as Health Care Services Firms, Hospices or Home Health Agencies but are licensed under Regulated Business by the NJ Division of Consumer Affairs (N.J.S.A 34:8-43). This may include Nurse Registries that offer private duty nursing or Employment/ Temporary Help agencies that offer Non-medical Companion service.

PLEASE PRINT OR TYPE

PRIMARY CONTACT

Company Name____

Contact person____

Title____

Address____

City______________________________State__________Zip__________

Phone__(____)______________________Fax___(___)______________________

E-Mail Address______________________ Web Address ______________________

Accreditation (If Applicable) ______________

ADDITIONAL EMPLOYEES- For Listserv & Other Communications

Name/Title ______________________________ **Email** ______________________

Name/Title ______________________________ **Email** ______________________

LICENSE INFORMATION – Copy of license required with application

Facility Type	License Number
Nurse Registry	
Non-Medical Companion Agency	
Other	

AGENCY DATA

Total Number of: Nurses____ PT____ OT____ ST____ SW____ CNA____ CHHA ____

Total Number of Employees (Admin & Field) __________ Number of Offices ______________

Patient Census (2009) ____________

Counties Served ____

Services Offered (use additional pages if needed) ______________________________

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ANNUAL DUES CALCULATION

We agree to pay our dues as follows:

( ) Annual (One Payment)*
1st payment due **January 10, 2010**

( ) Quarterly
1st payment due **January 10, 2010**
2nd payment due **April 10, 2010**
3rd payment due **July 10, 2010**
4th payment due **October 10, 2010**

( ) Semi-Annual
1st payment due **January 10, 2010**
2nd payment due **July 10, 2010**

Payment in full required if paying by credit card

*TOTAL 2009 Year End REVENUE	2010 AGENCY DUES	Check Below
0 to 250,000	$ 1,050	
250,001 to 500,000	$ 1,350	
500,001 to 1 Million	$ 2,100	
Over 1 Million	$ 4,200	

New applicants in operation for more than one (1) year must submit proof of prior year's financials, such as copies of tax returns, audited financial statements or cost reports, and certify that the information provided is true and accurate. Home care entities in operation for less than one (1) year must submit other available financial proofs acceptable to the Home Care Association, and certify that the information provided is true and accurate.

PAYMENT AGREEMENT

Contributions or gifts to the Home Care Association of New Jersey 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. That percentage of dues used for lobbying by the Home Care Association of New Jersey is not deductible as a business expense. The non-deductible percentage of dues is estimated to be approximately 10%.

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 agency is expected to honor this membership commitment through the end of dues/calendar year. Thus, notwithstanding a semi-annual or quarterly payment plan, membership dues are deemed due and owing in full on January 1 of the applicable year for existing members renewing membership, and the date membership is effective for new members. Thus, if a member terminates membership at any time during the applicable year, any and all outstanding unpaid dues for the year shall be due in full upon resignation or termination of membership. 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, including but not limited to financial information submitted in support of the determination of membership dues, 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 **Date**

PAYMENT

Membership Dues for Calendar Year 2010 = _______________

☐ **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**