CHAPCA ASSOCIATE MEMBERSHIP FORM

Organization Name: ____________________________________________________________

Organization Contact Name: ____________________________ Title: ____________________

Address: ___________________________________________________________________

City: __________________________ State: ______________________ Zip code: ____________

Phone Number: __________________________ Fax number: ________________________

Toll Free Number: ____________________________________________________________

Email Address: ______________________________________________________________

Website Address: _____________________________________________________________

CHAPCA Website Directory Listing

Listing Category:

____ Accreditation  ____ Billing  ____ Consulting Services  ____ Final Needs / Requests

____ Homecare Services  ____ Insurance  ____ Patient Care Supplies  ____ Technology  ____ Other _______________________

Contact to be listed on website (if different from above): ____________________________________________________________

Company Description (100 word limit):

________________________________________________________________________________________

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If you prefer, you may email your description to info@calhospice.org. We also accept logos.

Membership Agreement:

As an applicant to the California Hospice & Palliative Care Association, I/we do affirm to voluntarily abide by and support the goals and objectives of the organization. In addition, I/we agree to accept email communications from CHAPCA relative to the business of the Association.

__________________________________________________________ ____________________________
Signature of Applicant Printed Name Date

Dues to CHAPCA are not deductible as a charitable contribution but may be deductible as an ordinary and necessary business expense. However, a portion of dues is not deductible as a business expense to the extent that CHAPCA engages in lobbying. The nondeductible portion of dues is currently 7%.

Associate Member Dues: $800

Method of Payment:  ____ AMEX  ____ Mastercard  ____ VISA  ____ Check (Payable to CHAPCA)

Card No: __________________________ Exp Date: __________ Card ID #: __________________

Signature (required if using credit card) __________________________________________ Name on Credit Card (please print)

Card Billing Address City, State, Zip

Send ALL pages of application with payment to CHAPCA: 8153 Elk Grove Blvd. Suite 20 Elk Grove CA 95758 (mail)
info@calhospice.org (E-mail)