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): _____

_____

_____

_____

_____

_____

_____

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)