CHAPCA Associate Membership Form (2020)

Organization: _____

Contact: _____

Job Title: _____

Address: _____

City, State, Zip: _____

Phone: _____ **FAX:** _____

Toll Free #: _____

E-Mail: _____

Website Address: _____

CHAPCA WEBSITE LISTING:

Listing Category: ❒ Accreditation ❒ Billing ❒ Consulting ❒ Final Needs/Requests ❒ Homecare Services ❒ Insurance ❒ Patient Care Supplies ❒ Pharmacy Services ❒ 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 fax and e-mail communications from CHAPCA relative to the business of the Association and the Foundation.

_____ _____ _____

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 MEMBERSHIP DUES $800

Method of Payment:

❒ Check (Payable to CHAPCA) ❒ AMEX ❒ MasterCard ❒ Visa

Card No: _____ Exp. Date: _____ Card ID #: _____

_____ _____

Signature (required if using credit card) | Name on credit card (please print)

_____

Card Billing Address | City, ST, Zip

Send Application with Payment To:
P.O. Box 340698 Sacramento, CA 95834
info@calhopsice.org or 916-925-3780