



National Private Duty Association 2008 Associate Membership Application

Step One: Company Information

Contact Person (Person designated to receive mailings): _____

Provider/Company Name: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (____) _____ **Fax:** (____) _____

Toll Free Phone: (____) _____ **Individual E-Mail:** _____

Company E-Mail: _____ **Website:** _____

Date Business Established: _____

How did you learn of the National Private Duty Association? Website Newsletter Postcard Mailing

Referral – Whom may we thank? _____

Step Two: Dues Schedule

Associate Membership: A business that supplies goods and/or services to private duty home care agencies or their patients, but not NOT supply in-home personnel. Associate Members shall not have voting rights but can hold office or serve as an Officer or Director of the Association. They may also chair any standing committee of the Association. \$ 650.00

Contributions to NPDA are not deductible as charitable contributions for federal income tax purposes. However, your dues payment may be deductible as an ordinary and necessary business expense.

ASSOCIATE MEMBERS

Please check the type of products/services available to home health agencies:

- | | | |
|--|--|--|
| <input type="checkbox"/> Accounting | <input type="checkbox"/> Advertising Specialties | <input type="checkbox"/> Billing Services |
| <input type="checkbox"/> Clinical Laboratory | <input type="checkbox"/> Collections/Recovery | <input type="checkbox"/> Compliance Programs |
| <input type="checkbox"/> Consulting | <input type="checkbox"/> Employee Benefits | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Information Technology/ Information Systems | <input type="checkbox"/> IV Support | <input type="checkbox"/> Legal |
| <input type="checkbox"/> License Pending | <input type="checkbox"/> Medical Supplies | <input type="checkbox"/> Medical Bill Review |
| <input type="checkbox"/> Patient Charting Equipment | <input type="checkbox"/> Pediatric Products | <input type="checkbox"/> Pharmaceuticals |
| <input type="checkbox"/> Printing & Forms | <input type="checkbox"/> Risk Management | <input type="checkbox"/> Software & Support |
| <input type="checkbox"/> Staff Development & Training | <input type="checkbox"/> Staff Leasing | <input type="checkbox"/> Therapy Services |
| <input type="checkbox"/> Other _____ | | |

Note: If consulting firm please check what type of consulting services your company provides:

- | | | | |
|--|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Accreditation | <input type="checkbox"/> Billing | <input type="checkbox"/> Clinical | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Human Resources | <input type="checkbox"/> Information Technology/Information Systems | <input type="checkbox"/> Legal | <input type="checkbox"/> Management |
| <input type="checkbox"/> Other _____ | | | |

Step Three: Electronic version of the NPDA News

Your company can receive the **The Voice**, NPDA's newsletter electronically and save time and money! The electronic version of the **The Voice** can be delivered to as many of your staff as you request. Please fill in the name and email address of the person who would like to receive the **The Voice** via email. If you need additional space please send on a separate sheet.

Name _____	E-Mail _____
Name _____	E-Mail _____
Name _____	E-Mail _____
Name _____	E-Mail _____

Step Four: Sign and Submit Application with Payment

A. Signature Required

By this signature, I verify that the information provided on this application form is, to the best of my knowledge, correct. I understand that the membership benefits that we receive are only to be used by the company/provider listed in Step One and Two and its employees. Furthermore, I understand that these benefits may not be transferred to another licensed agency or business, which does not hold membership in this association. Any misuse of membership rights and benefits may result in the termination of our membership. I am aware that information on contacting my company will be available for viewing by the public on the NPDA website.

Administrator or Contact Person

Date

B. Payment Information

Check Enclosed

Credit Card: Visa MasterCard

Card # _____ Expiration Date _____

Authorized Signature: _____

Total amount enclosed of 2008 Membership Dues \$ \$650.00

Please make checks payable to:

NPDA

941 East 86th Street, Suite 270

Indianapolis, IN 46240

Phone: (317) 663-3637

FAX: (317) 663-3640

For office use ONLY

Date Paid _____

Cash

Check Check Number _____

Credit Card Authorization Number _____