2018 IHCA/INCAL Associate Member Application

Company Name: _____

Address: _____ City, State: _____ Zip: _____

Phone: _____ Fax: _____ Website: _____

Contact Person: _____ Contact Person's Email: _____

Company Category (circle up to 3)

Management and Operations
- Accounting
- Cost Reporting/Billing
- Consulting Services
- Education and Training
- Group Purchasing
- Insurance/Risk Management
- Legal Services
- Marketing
- Publishing
- IT/Software
- Financial Services

Maintenance
- Engineering, Design & Architecture
- Environmental Supplies & Services
- Clothing/Uniforms
- Flooring/Carpeting
- Furniture
- Heating & Cooling
- Housekeeping/Laundry
- Linens & Textiles
- Medical Waste & Disposal Treatment
- Restoration & Remodeling

Resident Care
- Food Service
- Hospital Services
- Medical Supplies & Equipment
- Nutrition
- Oral Health
- Physician Services
- Pharmaceuticals
- Rehabilitation/Therapy
- Security/Monitoring
- Transportation
- Wound Care
- Laboratory

IHCA E-Newsletter Distribution List

Please include the following email address on the distribution list for the IHCA IMPACT and other electronic communications:

Name: _____ Email Address: _____ Title: _____

Name: _____ Email Address: _____ Title: _____

Name: _____ Email Address: _____ Title: _____

2018 Associate Member Dues (circle one) **Standard Member - $500** ☐ **Key Member - $3,500** ☐

Title Member- Contact Emily Berger at eberger@ihca.org regarding availability

Dues for Associate Membership are collected on an annual basis and provide Associate Members benefits from the date of membership approval by the IHCA Board of Directors to December 31, 2018. Please be advised that pursuant to Federal tax law dues spent on lobbying and other related costs are not deductible for federal income tax purposes. The IHCA reasonably estimates that 25% of dues will be spent on lobbying costs for 2018.

Would you like to contribute a suggested $85 donation to the Indiana Health Care Foundation (IHCF) to benefit the long term care scholarship fund? Yes ☐ No ☐

Agreement and Payment

I understand that submission of this application is not a guarantee of IHCA membership and that this application must be approved by the IHCA Board of Directors. Approval of membership does not constitute endorsement by the IHCA of applicant or its products and/or services. I understand that membership benefits are only to be used by the applicant and its employees and that any misuse of membership rights and benefits may result in membership termination. If this application is approved, IHCA may use applicant's information in IHCA membership directories (both electronic and printed), and applicant consents to receive communications via regular mail, email, telephone, and/or fax sent by or on behalf of IHCA. **Payment of 2018 Associate Member Dues must accompany this application and will be processed upon receipt**. Payment will be refunded if membership is denied.

Payment form: ☐ Check payable to IHCA ☐ MC ☐ Visa ☐ Amex
Card Number: _____
Name on Card: _____
Exp. CVV Number:

_____
Signature Date

Send application with payment to:
Indiana Health Care Association
One North Capitol, Suite 100
Indianapolis IN 46204
Attn: Emily Berger