



## 2019 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: \_\_\_\_\_

**2019 Associate Member Dues (circle one) Standard Member - \$500 Key Member - \$3,500**

**Title Member- Contact Emily Berger at [eberger@ihca.org](mailto: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, 2019. 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 23% of dues will be spent on lobbying costs for 2019.

**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 2019 Associate Member Dues must accompany this application and will be processed upon receipt.** Payment will be refunded if membership is denied.

\_\_\_\_\_  
Signature Date

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

Payment form:  Check payable to IHCA  MC  Visa  Amex

Card Number: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Exp. CVV Number: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Billing City: \_\_\_\_\_ Billing State: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_