

2010 ALLIED MEMBER APPLICATION



Voluntary non-profit and public organizations that do not provide home care services directly, but are interested in home care, or out-of-state home care providers, are welcome to join the Association as an **Allied Organization member**.

Agency/Organization _____

Address _____ City/State/Zip _____

Main Phone _____ Fax _____ Website _____

Contact _____ Title _____

Direct Line _____ Email _____

Please check the appropriate category:

Category	Dues Amount
<input type="checkbox"/> Local, Statewide or National not-for-profit Organizations with an annual budget <u>over</u> \$2 Million (<i>not providing home care services</i>)	\$1,000
<input type="checkbox"/> Local, Statewide, or National not-for-profit Organizations with an annual budget <u>under</u> \$2 Million (<i>not providing home care services</i>)	\$850
<input type="checkbox"/> Non-Profit Health Insurers and HMOs, or out-of state home health providers	\$1,000

Total 2010 Dues \$ _____
Authorized Signature _____ Date _____

Method of Payment

Charge the full amount to credit card Visa Mastercard American Express Discover

Card Number _____ Expiration Date _____ Printed Name _____ Authorized Signature _____

Check will follow for the full amount payable to Home Care Association of NYS

Please fax your application to the renewal fax line at 518.426.8788 or mail to the address below.