



FLORIDA ALLIANCE OF HOME CARE SERVICES 2009 MEMBERSHIP APPLICATION

COMPANY INFORMATION

Company Name: _____

DBA: _____

Contact Person/Title: _____

Address: _____

City: _____ Zip: _____ State: _____ Yr Established: _____ # of Employees _____

Office # _____ Fax# _____ Cell# _____

Email: _____ Alt Email: _____

Residential Zip Code of Owner/Manager: _____ Referred By: _____

Name of Billing Software: _____

Name of Billing Service (Contact) _____ Tel#: _____

List your top issues in HME: Medicaid Medicare Inspections other _____

HME provided by your company (Circle All)

APMs • BiPAP • CPAP • CMS • Complex Rehab • Enteral • Hospital Beds • Homefill Oxygen •
Liquid Oxygen • Nebulizer Medications • Power Wheelchairs • Trache Patients • Ventilators

NOTE: The above is privileged information. It will not be released or used for solicitation

PAYMENT INFORMATION

MEMBERSHIP FEE - \$400 Per Company / Per Year (\$50 Discount for VGM or AAHomecare members)
 VGM AA Homecare AMEPA

Amount to Charge: \$ _____ Signature: _____ Date: _____

Credit Card M/C VISA AMEX - Card # _____

Exp Date _____ V-Code (3 digit - 4 digit for AMEX) _____ Billing Zip Code: _____

Please fax the application with your Credit Card information or send a check.

