



1520 High Street
Des Moines, IA 50309
www.iowahomecare.org

Associate Membership & Sponsor Level Application

The information on this form is used to calculate your company's membership dues, update our member database, and verify data to be listed in our online Associate Membership directory.

"Associate" membership is available to any institution or organization interested in Iowa home care issues but which does not meet IAHC requirements for "Provider" membership.

Company Information (as it should be listed in the online directory – PLEASE PRINT OR TYPE)

Annual Associate Membership fee of \$490, plus selected sponsorship level payment, must accompany this Associate Member Application. Membership year and benefits begin with receipt of payment. IAHC dues are not refundable. Note: Associate members are not eligible to vote on IAHC matters.

Company Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Website: _____

IAHC Sponsorship Level (check one of the following):

Note: "Associate Membership" included in sponsorship fee. See Sponsor information packet for details

- ____ **Platinum Sponsor** (\$5,000/yr)
- ____ **Gold Sponsor** (\$3,750/yr)
- ____ **Silver Sponsor** (\$2,500/yr)
- ____ **Bronze Sponsor** (\$1,250/yr)
- ____ **Associate Member** only (\$490/yr)

Print name of individual completing Application

Signature

Is your company interested in exhibiting at the IAHC Annual Conference Expo?

___ Yes ___ No

Does your company have staff available for on-site or online presentations?

___ Yes ___ No

If yes, please list the names and contact information of these employees:

Associate Member Profile

Briefly describe your company's products/services (limit of 50 words):

Buyer's Guide Category (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Accounting Services | <input type="checkbox"/> Legal Counsel |
| <input type="checkbox"/> Computer Hardware/Software | <input type="checkbox"/> Medical Supplies |
| <input type="checkbox"/> Data Collection/Submission | <input type="checkbox"/> TeleMedicine Products |
| <input type="checkbox"/> Home Care Consultants | <input type="checkbox"/> Therapy (IV, Respiratory) |
| <input type="checkbox"/> Home Medical Equipment | <input type="checkbox"/> Wound & Skin Care |
| <input type="checkbox"/> Insurance Products | <input type="checkbox"/> Other (specify) |

Refunds: There are no refunds for membership dues

Payment Information:

<input type="checkbox"/> Credit Card CC Type: Visa, MasterCard, Discover, Diners Club, JCB	<input type="checkbox"/> Check Amt Enclosed: \$
---	--

Card Holder's Name: _____

Card Number: _____

Expiration Date: _____ Security Code: _____

Billing Address: _____

Card Holder Signature: _____

Fax completed registrations to (515)282-8034 or mail with payment to:
Iowa Alliance in Home Care, 1520 High Street, Des Moines, IA 50309

FOR IAHC USE Auth Code: _____	Trans ID: _____	Date Processed: _____
----------------------------------	-----------------	-----------------------