

CHAPCA Associate Membership Form

Organization: _____
Contact: _____
Job Title: _____
Address: _____
City, State, Zip: _____
Phone: _____ FAX: _____
Toll Free #: _____
E-Mail: _____
Website Address: _____



CHAPCA WEBSITE LISTING:

Listing Category: Accreditation Billing Consulting Final Needs/Requests Homecare Services Insurance
 Patient Care Supplies Pharmacy Services Technology Other _____

Contact to be listed on website (if different from above): _____

Company Description (100 word limit): _____

If you prefer, you may email your description to info@calhospice.org.

Membership Agreement:

As an applicant to the California Hospice & Palliative Care Association, I/we do affirm to voluntarily abide by and support the goals and objectives of the organization. In addition, I/we agree to accept fax and e-mail communications from CHAPCA & CHF (California Hospice Foundation) relative to the business of the Association and the Foundation.

Signature of Applicant

Printed Name

Date

Dues to CHAPCA are not deductible as a charitable contribution but may be deductible as an ordinary and necessary business expense. However, a portion of dues is not deductible as a business expense to the extent that CHAPCA engages in lobbying. The nondeductible portion of dues is currently 7%.

ASSOCIATE MEMBERSHIP DUES \$500

Method of Payment:

Check (Payable to CHAPCA) AMEX MasterCard Visa

Card No: _____ Exp. Date: _____ Card ID #: _____

Signature (required if using credit card)

Name on credit card (please print)

Card Billing Address

City, ST, Zip

Send Application with Payment To:
CHAPCA, 3841 North Freeway Blvd., Ste. 225, Sacramento, CA 95834; FAX 916-925-3780