



2017 BUSINESS PARTNER APPLICATION

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The information on this form is used for the term of one year from January 1, 2017 through December 31, 2017, to create your company's profile in our database system, and to be listed on our vendor directory. Complete and return this form to MHCA.

DUES COMPUTATION

Business Partners are organizations, vendors, or individuals affiliated with health-related organizations, interested in home health care through the provision of services or products to our industry, or recognized as having contributed to the promotion of home care. Examples include suppliers of equipment, services and technology to home care agencies.

NOTE: Business Partners of MHCA are non-voting members. Organizations eligible for "Provider" member status are not eligible to join as a "Business Partner" member. Dues or gifts to MHCA are not tax deductible as charitable contributions for income tax purposes.

Prorated fees: New members who join after January 31 are prorated from the month joined to the end of the calendar year. Dues must be paid in full at the time of application to receive the discount.

Dues are nonrefundable.

2017 BUSINESS PARTNER DUES:	\$	675
PRORATED AMOUNT	=	(\$)
TOTAL	=	\$
<i>Prorated membership dues must be paid in full at the time of application to receive discount.</i>		
PAYMENT METHOD		
<input type="checkbox"/> Bill Me <input type="checkbox"/> Check <input type="checkbox"/> Credit Card		
<i>Credit card payments will be assessed a 3% credit card usage fee.</i>		
Credit Card #:		
Exp. Date:	Security Code:	
Name on Card:		
Card Holder Signature:		

COMPANY INFORMATION

Company Name:
Business Address:
Phone:
Fax:
Toll-Free:
Website:
Geographic area your company serves within MN: (Check all that apply)
<input type="checkbox"/> Twin Cities / Metro
<input type="checkbox"/> Greater MN

Company Name:

Description of products/services provided to home care agencies: *(Limit of 40 words)*

BUYER'S GUIDE CATEGORY: *(Check all that apply)*

- | | | |
|--|---|---|
| <input type="checkbox"/> Accounting Services | <input type="checkbox"/> Home Care Consultants | <input type="checkbox"/> Printing/Marketing |
| <input type="checkbox"/> Administrative Management | <input type="checkbox"/> Home Medical Equipment | <input type="checkbox"/> Telehealth |
| <input type="checkbox"/> Business Office Needs | <input type="checkbox"/> HR Services | <input type="checkbox"/> Therapy Services (IV, Respiratory) |
| <input type="checkbox"/> Computer Hardware/Software | <input type="checkbox"/> Insurance Products | <input type="checkbox"/> Wound & Skin Care |
| <input type="checkbox"/> Data Collection/Submission | <input type="checkbox"/> Legal Counsel | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Electronic Health Records (EHR) | <input type="checkbox"/> Medical Supplies | |

THE DATA BELOW WILL BE USED ONLY FOR MHCA'S REFERENCE:

Are You a Member of the Following Associations?

- | | | |
|---|------------------------------|-----------------------------|
| • National Association for Home Care (NAHC) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Visiting Nurse Association of America (VNAA) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Care Providers of Minnesota | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • LeadingAge Minnesota | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Minnesota First Provider Alliance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • MN Network of Hospice and Palliative Care (MNHPC) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PRIMARY ADMINISTRATIVE CONTACTS

It is recommended that you assign an individual to be the agency's **Primary Contact Person**. This person will receive all mailings, emails and dues renewals on behalf of the company.

Name:

Alternate address if different from company's address:

Direct Phone:

Alternate Phone:

E-mail Address: