



FLORIDA ALLIANCE OF HOME CARE SERVICES
REGULAR MEMBERSHIP APPLICATION - 2018

COMPANY INFORMATION

Company Name: _____ dba: _____

Contact Person: _____ Title: _____

Address: _____

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

Office # _____ Fax# _____ Cell# _____

Email: _____ Alt Email: _____

Name of Billing Software: _____

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

HME provided by your company (Circle All): APMs • BiPAP • CPAP • Wheelchair • Complex Rehab • Enteral • Hospital Beds

- Oxygen • Liquid Oxygen • Nebulizer Medications • Power Wheelchairs • Trach Patients • Ventilators • Incontinence

NOTE: The above is privileged information. It will not be released or used for solicitation. Up to 50% can be used for lobbying purposes.

PAYMENT INFORMATION - FAX, SCAN OR PAY ONLINE at www.fahcs.us/membership

MEMBERSHIP FEE - \$400 Per Company / Per Year

I am also a member of: [] AAHomecare [] VGM [] MEDGroup

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 to secure fax number below or send a check

FAHCS - 800 Ocala Rd., Suite 300-220, Tallahassee, FL 32304

www.FAHCS.us - info@FAHCS.us

Phone 919-387-1221 - Fax: 919-249-1394