



# FLORIDA ALLIANCE OF HOME CARE SERVICES

## REGULAR MEMBERSHIP APPLICATION - 2019

### COMPANY INFORMATION

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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.*

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### PAYMENT INFORMATION - FAX, SCAN OR PAY ONLINE at [www.fahcs.us/membership](http://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

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

[www.FAHCS.us](http://www.FAHCS.us) - [info@FAHCS.us](mailto:info@FAHCS.us)

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