



Utah Association for Home Care

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E-mail: homecareconnection@msn.com
Website: www.ua4hc.org

2008 Membership Application

<input type="checkbox"/> New	<input type="checkbox"/> UHPCO Member
<input type="checkbox"/> Renewal	<input type="checkbox"/> NAHC Member
Initial UAHC Membership Date _____	

Complete one (1) application for each office location exactly as desired on web listing and return with payment to address listed above.

** AGENCY INFORMATION <input type="checkbox"/> Main Office <input type="checkbox"/> Branch Location Agency _____ Address _____ City _____, UT Zip _____ Phone (_____) _____ Fax (_____) _____ Toll Free _____	** CONTACT PERSON(S) NAME _____ E-Mail _____ NAME _____ E-Mail _____ Cell (_____) _____	** VOTING Representative
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**** SERVICE AREAS**
This section **MUST** be completed for each office location for agency to appear on website!

<input type="checkbox"/> Beaver	<input type="checkbox"/> Iron	<input type="checkbox"/> Sevier
<input type="checkbox"/> Box Elder	<input type="checkbox"/> Juab	<input type="checkbox"/> Summit
<input type="checkbox"/> Cache	<input type="checkbox"/> Kane	<input type="checkbox"/> Tooele
<input type="checkbox"/> Carbon	<input type="checkbox"/> Millard	<input type="checkbox"/> Uintah
<input type="checkbox"/> Daggett	<input type="checkbox"/> Morgan	<input type="checkbox"/> Utah
<input type="checkbox"/> Davis	<input type="checkbox"/> Piute	<input type="checkbox"/> Wasatch
<input type="checkbox"/> Duchesne	<input type="checkbox"/> Rich	<input type="checkbox"/> Washington
<input type="checkbox"/> Emery	<input type="checkbox"/> Salt Lake	<input type="checkbox"/> Wayne
<input type="checkbox"/> Garfield	<input type="checkbox"/> San Juan	<input type="checkbox"/> Weber
<input type="checkbox"/> Grand	<input type="checkbox"/> San Pete	
<input type="checkbox"/> All counties listed above	<input type="checkbox"/> Outside Utah	

Payment Sources - check all that apply

<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Pay	<input type="checkbox"/> N/A
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Insurance / Third Party	

Organization Staff

S = Service Provided by Staff
A = Arranged / Contracted

Private Duty

<input type="checkbox"/> RN _____	<input type="checkbox"/> CNA/Aide _____	<input type="checkbox"/> Live In _____
<input type="checkbox"/> LVN/LPN _____	<input type="checkbox"/> Homemaker _____	<input type="checkbox"/> N/A

Intermittent Services

<input type="checkbox"/> RN _____	<input type="checkbox"/> PT _____	<input type="checkbox"/> ST _____
<input type="checkbox"/> LPN _____	<input type="checkbox"/> OT _____	<input type="checkbox"/> RT _____
<input type="checkbox"/> CNA/Aide _____	<input type="checkbox"/> SW _____	<input type="checkbox"/> Dietitian _____
<input type="checkbox"/> Medical Director _____	<input type="checkbox"/> Enterostomal Technician _____	
<input type="checkbox"/> Psychiatric RN _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> N/A

**** ORGANIZATION OWNERSHIP / TYPE - check all that apply**

<input type="checkbox"/> Freestanding Agency	<input type="checkbox"/> Hospice
<input type="checkbox"/> Hospital-Based Agency	<input type="checkbox"/> Ambulatory Infusion Agency
<input type="checkbox"/> Government Agency	<input type="checkbox"/> IV Therapy Agency
<input type="checkbox"/> Private For-Profit Agency	<input type="checkbox"/> Home Medical Equipment Supplier
<input type="checkbox"/> Not-for-Profit Agency	<input type="checkbox"/> Visiting Nurses Association

Home Infusion Services

<input type="checkbox"/> RN _____	<input type="checkbox"/> Pharmacist _____	<input type="checkbox"/> N/A
<input type="checkbox"/> Delivery Driver _____	<input type="checkbox"/> Pharmacy Technician _____	

CERTIFICATION / ACCREDITATION - check all that apply

<input type="checkbox"/> CHAP _____	<input type="checkbox"/> Medicare _____	<input type="checkbox"/> HME _____
<input type="checkbox"/> JCAHO _____	<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> ACHC _____
<input type="checkbox"/> State Licensed, Nursing _____	(Accreditation Commission for Home Care)	
<input type="checkbox"/> State Licensed, Personal Care _____		
<input type="checkbox"/> State Licensed, Pharmacy _____		

Additional Services

<input type="checkbox"/> Apnea Monitoring	<input type="checkbox"/> Home IV Therapy	<input type="checkbox"/> Rehabilitation Home Care
<input type="checkbox"/> Case Management	<input type="checkbox"/> Phototherapy	<input type="checkbox"/> Nutritional Counseling
<input type="checkbox"/> HME / DME	<input type="checkbox"/> PICC Line Insertion	
<input type="checkbox"/> Home Dialysis	<input type="checkbox"/> Post-Partum Care	

Formal, Organized Disease Management Programs

<input type="checkbox"/> AIDS	<input type="checkbox"/> COPD	<input type="checkbox"/> Neonates	<input type="checkbox"/> Ventilator
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Oncology	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Maternity	<input type="checkbox"/> Pediatrics	
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Terminal Care	<input type="checkbox"/> N/A

Infusion Therapy Services

<input type="checkbox"/> Aerosolized Pentamidine	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Cardiac Drugs
<input type="checkbox"/> Pain Management	<input type="checkbox"/> Enteral	<input type="checkbox"/> TPN
<input type="checkbox"/> Pharmacy Consultation	<input type="checkbox"/> Hydration	
<input type="checkbox"/> Tocolytic Therapy	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> N/A
<input type="checkbox"/> Growth Hormone	<input type="checkbox"/> Blood Products	

UAHC MEMBERSHIP DUES AND RATES
(please check all that apply and enter amount in TOTAL DUE)

<input type="radio"/> New Agency (licensed after 06/2007).....	\$ 200.00
<input type="radio"/> Small HHA (1 or 2 branches).....	\$ 400.00
<input type="radio"/> Rural HHA.....	\$ 400.00
<input type="radio"/> Large HHA (3 or more branches).....	\$ 800.00
<input type="radio"/> Large HHA (annual revenue over \$3 million)....	\$ 800.00
<input type="radio"/> Associate Membership*.....	\$ 100.00
<input type="radio"/> HME/DME Providers	\$ 100.00
<input type="radio"/> IV Infusion Providers	\$ 100.00
<input type="radio"/> Individual Membership	\$ 100.00
<input type="radio"/> Personal Care Agency	\$ 100.00

**** PAYMENT METHOD**

Please mail completed form with check made payable to: **UAHC**

TOTAL DUE \$ _____

Check Enclosed

Credit Card Payment Information - 3% processing fee will be added

- American Express
- Discover Card
- Master Card
- Visa

Exp Date _____/_____/_____

Card No. _____

Name on Card _____

Signature _____

* UAHC offers associate memberships for agencies in allied industries.

** Required fields

Please notify office of any changes immediately!