Home Care & Hospice
ALLIANCE OF MAINE

Licensed/Registered Membership Form
2013 – 2014 Membership Year

Name of Agency: _____

(Please check one) State Licensed _____ Registered _____

Contact Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Website: _____

IMPORTANT: Note that the information above will be used for all listings including the Alliance's website. Please be sure that ALL information is current and accurate.

Report the revenue for the most recent fiscal year.

Home Care Services (Annual Patient Revenue) $_____

Total Annual Dues (See Dues Calculation Chart) $_____

Please check one of the following:

☐ Check for total amount due is enclosed.

☐ Check for 1st quarter dues is enclosed. Please bill me quarterly for the remainder of the year.

☐ No check enclosed. Please bill me quarterly for the year.

Agreement: *I have read and agree to comply with the Alliance's Provider Membership and Dues Policy.*

_____ _____

Signature Date

You may fax the completed form to: 207-213-6127, or return by mail to:

Home Care & Hospice Alliance of Maine

PO Box 227, Manchester, Maine 04351-0227

If you have any questions, please contact the Alliance at 207-213-6125.

Licensed/Registered Provider
Dues Calculation Chart

Please use the following chart to determine the annual dues amount for your agency.

Annual patient revenue is based on total patient income for all home care related services.

Total Revenue	Dues Amount
$0 – $500,000	$750
$500,001 – $1,000,000	$1,000
$1,000,001 – $2,000,000	$1,250
$2,000,001 – $3,000,000	$1,500
$3,000,001 - $4,000,000	$1,750
$4,000,001 – $5,000,00	$2,000
$5,000,001 *and over*	$2,500