



Texas Hospital Home Health Association

P.O. Box 203878
Austin, TX 78720
512/873-0045

MEMBERSHIP APPLICATION

Date _____

Membership Category Applied for: _____ Regular _____ Corporate _____ Affiliate

REGULAR MEMBERSHIP

Name of Hospital _____

Address of Hospital _____

City _____ Zip _____ Phone _____ Fax _____

Administrator _____ Email _____

Name of Home Health Care Program _____

Address _____

City _____ Zip _____

Phone _____ Fax _____

Program Director _____ Email _____

Home Health Program is: _____ in operation _____ being planned

If you have multiple home health programs, please list the locations on the reverse side of this application. Regular Membership in the THHHA is held by the hospital providing the home health care program. The hospital administrator and the home health program director will receive all correspondence and information provided by the association.

CORPORATE / AFFILIATE MEMBERSHIP

Company/Organization _____

Address _____

City _____ Zip _____ Phone _____ Fax _____

Contact Person and Title _____ Email _____

Type of Business/Organization _____

Type of Business (25 words or less) _____

MEMBERSHIP DUES

Regular Member: \$495.00

Corporate Member: \$250.00

Affiliate Member: \$100.00

Make check payable to THHHA and mail to PO Box 203878, Austin, TX 78720

Texas Hospital Home Health Association

CREDIT CARD PAYMENT FORM

Please Print Clearly

Total Amount Paid:	_____	Date:	_____
Name as it appears on card:	_____		
	<i>Company and/or Individual Name</i>		
PERSON AUTHORIZED TO CHARGE:			
First Name:	_____	Last Name:	_____
Card Type:	<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> AMERICAN EXPRESS <input type="checkbox"/> DISCOVER
Card Number:	_____	Expiration Date:	_____
Card Security Code:	_____		
Signature Authorizing Charge:	_____		
Email Address:	_____		
Telephone Number:	_____		

BILLING ADDRESS

Please enter the following information exactly as it appears on your credit card statement

Address:	_____		
City:	_____	State:	_____
Zip:	_____		

Payment cannot be processed unless all information is provided.

You may fax the completed form to (512) 873-0046