

Texas Hospital Home Health Association

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 _____

Description 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 14547, Austin, TX 78761