2019 DAHCC Membership Application

Your membership and dues contribution help make it possible for DAHCC to continue our shared commitment to education, quality, safety, and access to home health care in Delaware.

DAHCC membership is open to all providers of home and community based service. Annual dues are based on the following levels:

Agency Membership *(for agencies with the following levels of licensure: 4406 Aide only, 4410 Skilled, 4469 PASA, and 4468 Hospice)*

Bronze membership:	Organization with annual revenue < 1 million	**$200**
Silver membership:	Organization with annual revenue 1-3 million	**$400**
Gold membership:	Organization with annual revenue > 3 million	**$600**

Agency membership entitled to:

a. Membership on the Advisory Board and participation in its activities.
b. A vote in DAHCC activities.
c. Appointment of an individual staff member to represent the agency on the Board, although more than one member may attend and participate.
d. The right to display the DAHCC membership logo.
e. Inclusion in list of DAHCC agency memberships on the website.
f. Unlimited attendees to general membership meetings.

Associate Membership *(Organizations or Individuals who are not licensed as above)* **$100**

Associate membership entitled to:

a. Attend general membership meetings.
b. Inclusion in list of DAHCC associate memberships on the website.
c. These members are not eligible to participate in Advisory Board activities unless invited for a special purpose; these members are not eligible to vote in DAHCC activities

Please complete the information form on page (2) to apply and enclose your check payable to:

Delaware Association for Home and Community Care
PO Box 7037
Wilmington DE 19803

Please return by January 14, 2019

2019 DAHCC Membership Application Form

Membership Level *(check one):*

Gold ________ **Silver**________ **Bronze** ________ **Associate** ________

Member Contact information *(please print)*:

Organization: ____

Address: ____

____

Phone: ____

Web: ____

Agency Primary Representative *(please print):*

Name/Title of Agency Representative: ____

Phone: ______________________________E-mail: ____

Agency Alternate Representative *(please print):*

Name/Title of Agency Representative: ____

Phone: ______________________________E-mail: ____

Signature of person authorized to sign for agency:

Signature: ____ Date: _____________________

Print name: ____

Enclose completed form and check payable to:

Delaware Association for Home and Community Care
PO Box 7037 *(Note: New Post Office Box Number)*
Wilmington DE 19803

Return by January 14, 2019