



Associate Membership Application Check-off Sheet

Please use this list to verify that you have included all of the necessary forms, as well as any additional paper work and documentation required by AZNHA to complete the application process.

Please make sure to answer all the questions on the forms. You DO NOT need to send this page to us. Please include the following in the packet you fax, email, or mail to AZNHA:

- ☐ 1. The completed, signed and dated original of the Association's membership application (pg.6)
- ☐ 2. Annual dues of \$400 is payable to AZNHA. All memberships are processed on on a twelve month cycle.
- ☐ 3. For providers in the health care services industry only: Copies of insurance coverage for workers compensation, liability and, if applicable, your professional liability (fidelity/theft bond) for caregiver employees. These can be obtained from your insurance agent and are usually provided on an ACORD® form. You may choose to request that your insurance carrier name AZNHA as a certificate holder (AZNHA would automatically receive renewal and updated information).
- ☐ 4. Electronic copy of your company logo (in .jpg or .eps format) for placement on our website. If you have any questions regarding this Application Packet, please feel free to call us at 480-491-5627. The completed application packet can be faxed, emailed, or mailed to:

Fax: 866-225-4610

Email: info@AZNHA.org

Post: Arizona In-Home Care Association
1922 E Fairmont Dr
Tempe, Arizona 85282-5831

Arizona In-Home Care Association

1922 E Fairmont Drive
Tempe, AZ 85282-5831
480-491-5627

<https://AZNHA.org>

info@AZNHA.org



Application for Associate Membership

A. Applicant Identification:

Date: _____

Registered/Corporate/Business Name: _____

DBA's or Name Known to Customers: _____

Address: _____
Street City State Zip

Office Phone: _____ Office Fax: _____

Primary contact person name: _____

Email Address: _____ Web Site Address: _____

Counties in which services are provided: _____

Applicant's Business Office Hours/Days: _____

If applicant is in the health care industry, please provide:

Service Hours: _____ Office Staff Availability: _____

Is your organization an approved AHCCCS provider? ☐ Yes ☐ No.

B. Licensure & Certification: (Only if you are in the health care field, i.e. hospice.)

State License # (if applicable): _____

Are any of your employees licensed or certified in any capacity of health or home care? Yes ☐ No ☐

C. Business Ownership:

Please provide the names, titles, and addresses for all of your company officers, owners and managerial employees. (Attach additional sheet if necessary)

_____ Name	_____ Title	_____ Name	_____ Title
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_____ Name	_____ Title	_____ Name	_____ Title
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How long have the individuals listed above owned and operated this business? _____

List other office locations. (Attach additional sheet if necessary)

Address: _____
Street City State Zip

Office Phone: _____ Office Fax: _____

Primary contact person name: _____

Email Address: _____ Web Site Address: _____

Counties in which services are provided: _____

Address: _____
Street City State Zip

Office Phone: _____ Office Fax: _____

Primary contact person name: _____

Email Address: _____ Web Site Address: _____

Counties in which services are provided: _____



Have any applicant Officers, Directors, Owners, or Managerial Employees ever been convicted of a criminal offense, other than a minor traffic violation? Yes ☐ No ☐

If Yes, please attach a brief explanation.

Have any of the owners, officer, principals, or managerial employees of your organization been involved in, had interest in, or owned a non-medical or other health care business that has either shut down its operations or went out of business? Yes ☐ No ☐

If Yes, please attach a brief description including; dates of operation, circumstances and the involvement and position of the individuals on this application in said business.

Have any of your organization's owners, officers, principals, or managerial employees had their license or certification revoked or suspended, or had any other disciplinary action taken against them by a licensing body? Yes ☐ No ☐

If Yes, please provide a brief explanation:.

D. Services Offered

Please list and/or explain the services you offer:

E. Privacy and Disclosure Policy Acknowledgments

Non-Confidential Business Information: Certain business information we collect from Applicants and Members is considered public information by the Association (rather than information about you individually, such as your personal or financial information, etc.). For these purposes, we have defined "Non-Confidential Business Information" as any information for public review that identifies, or may identify, a company, its business practices, policies and procedures, its employees, or an individual contact at a company or that allows others to contact a company or an individual contact at a company that is *not* considered by the Association to be "Confidential Business Information."

Member's Profile: We also collect Business Information when you submit an Application for process by the Association. This information includes contact information and certain other information about you and/or your business and the services your business may provide. We use this information in accordance with this policy to identify you, your business, and to process your Application. In addition, this Information is used to create a "Member Profile" that is posted on the Association's Web Site and available for the public to review.

Release Statement: I, the undersigned, grant the Arizona In Home Care Association (the "Association"), and/or its authorized agents, the rights to use the Non-Confidential Business Information contained herein, as defined above, for informational, publicity, or promotional purposes without prior notification. I understand that this Business Information may appear in printed materials published by the Association, on the Association's Web site, in the Association's presentations or exhibits, in newspapers or magazines, or



on television. I agree to hold the Association and its Members harmless from all claims related to the Association's or its agents' use of this Non-Confidential Business Information for these purposes. I also agree that the Association is under no obligation to me or any other party to use this Non-Confidential Business Information. By my signature below, I represent that I have read and fully understand this Application for Membership Form.

Application Verification Statement: I hereby authorize the Arizona In Home Care Association, its agents, officers, directors, staff, or private investigators, to make inquiries, either by written communication, telephone, electronic, in person or otherwise, to any current or former business associate, governmental agency, educational institution, military establishment, relative or any other persons or entities knowledgeable of backgrounds of the individuals listed on this Application as to their prior history, without limitation, their: criminal history, business records or personal background; Corporate directorship/ownership, interest in business(es), nature of business of business dealings; prior claims, lawsuits, settlements; educational background, licenses, and certifications, work experience, nature of duties, performance levels; reliability, responsibility, honesty, integrity, civility, and any other measures of their character or personality.

In consideration of the furnishing of any such information by any party contacted by or on behalf of Arizona In Home Care Association, I and the business entity I represent, specifically waive any confidential relationship or privacy right which may exist for my (our) benefit and completely release the Arizona In Home Care Association, and the party(ies) contacted from any responsibility or liability for damages or other injuries which may occur as a result of the release or disclosure of this information. I, and the business entity I represent, agree to indemnify and hold harmless anyone involved with the conduction of this investigation of my, or the business entities, background from any and all liabilities or claims in connection therewith, photocopy, fax or electronic copy of this instrument bearing my signature shall be equally legally valid as the original.

F. Applicant Verification

I certify that to the best of my knowledge, that the information provided herein is accurate and complete. I further agree, in the event the business I represent becomes a Member of the Association that all disputes and claims, individual or severable, involving this Membership will be submitted to the Association's Board of Directors for final resolution. The decision rendered by the Board of Directors regarding any Member dispute or claim is binding, final, and cannot be appealed.

Name of Company: _____

Signature of Authorized Agent: _____

Name (please print or type): _____

Title: _____ Today's Date: _____



CODE OF BUSINESS ETHICS & CREDENTIALING STANDARDS OF SERVICE AGREEMENT

To be eligible to join and maintain a membership in good standing in the **Arizona In Home Care Association**, Associate Members must adhere to the following:

1. Supply background information about the company, its principals and/or other information deemed essential to the AZNHA's responsibility to provide consumers with factual information of its Members.
2. Promptly notify the AZNHA of any changes in ownership, licensing status, addresses, telephone numbers, website and other information deemed necessary by the AZNHA.
3. Maintain workers compensation insurance for all employees.
4. Maintain liability insurance and a bond/insurance against theft that covers the acts of all employees.
5. Not be engaged in a type of business practice that historically generates unresolved complaints or patterns of complaints.
6. Promptly respond to any and all member and nonmember complaints' presented by the AZNHA, and make a good faith effort to resolve all such complaints in accordance with generally accepted good business practices.
7. Adhere to established AZNHA's Code of Business Ethics and Practices.
8. Support AZNHA's efforts to voluntarily self-regulate the non-medical home care industry.
9. Fulfill all licensing and bonding requirements as required by your industry, applicable city, county, state and federal agencies and authorities, provide appropriate license numbers upon application for AZNHA membership and provide periodic update information upon request.
10. Refrain from using the name, logo, seal, or any other materials of the AZNHA for commercial, sales or advertising purposes in any manner not specifically authorized in writing by the AZNHA, or if the membership is suspended or terminated.
11. Remain free from any governmental action, concerning the marketplace, your industry and its customers, that demonstrates a significant failure of the Member's business to support the principles and purposes of the Association. A membership may be temporarily suspended by the AZNHA's board when an action is filed against a Member alleging such a failure.
12. Support the principles and purposes of the AZNHA and not engage in activity that, in the determination of the AZNHA, reflects adversely on the Association or its members.

As an employer, the Member's business maintains a payroll process which includes reporting of employment wages to the appropriate governmental agency; collecting state and federal withholding payroll taxes; and the payment of these taxes and all other state and federal payroll taxes to the appropriate governmental institution.

Maintain current Arizona and Federal labor code postings, and other pertinent labor law posters as required by law.

Not be engaged in a type of business practice that historically generates unresolved complaints or patterns of complaints.



Promptly respond to any and all member and nonmember complaints' presented by the AZNHA, and make a good faith effort to resolve all such complaints in accordance with generally accepted good business practices.

Adhere to established AZNHA's Code of Business Ethics and Practice.

Any Member and/or Member's business may be suspended or terminated for cause of conduct which is at variances with these standards or other AZNHA policies and procedures.

I, and the business entity I represent, agree to comply with the Association's Code of Business Ethics & Credentialing Standards of Service Agreement as set forth above. I understand and agree that failure to comply with this Agreement can result in an investigation into a member's conduct, and can result in disciplinary measures by the Association, including suspension or expulsion from AZNHA.

Company _____

Signature: _____ Title: _____

Printed Name: _____ Date: _____



AZNHA Membership Payment form

Effective January 1, 2022, annual membership dues are \$400 per Member Company. All Renewals are processed on a twelve month cycle.

Member Identification:

Company Name: _____

Primary contact person name: _____

Email Address: _____

Payment Information:

☐ By Check (payable to AZNHA) ☐ by Credit Card (complete the form below)

Credit Card Information:

Card holder name _____ Phone _____

CC billing address: _____
Street address City State Zip

Email address _____

Card Type: ☐ Visa ☐ MasterCard ☐ AmEx Amount paid: \$ _____

Card # _____ Exp. Date: ____/____ CSC # _____

Authorized Signature: _____ Date: _____

Notes: If primary contact and cardholder are not the same, please let us know to what email the PayPal receipt should sent.

☐ Primary Contact ☐ Cardholder

Do you wish to receive an AZNHA receipt for this charge (sent via email)? ☐ Yes ☐ No

Note: If primary contact and cardholder are not the same, please let us know to what email the PayPal receipt should sent. Credit card payments can only be made from this form. AZNHA uses PayPal for credit card processing. Once PayPal has advised the payment has been accepted, all credit card information is blacked out from this, or any other form. No credit card information will ever be kept on file at AZNHA.

Arizona In-Home Care Association

PO Box 8042, Tempe, AZ 85281

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