



## Regular /Associate Membership Application

The NHCA is an association of healthcare owned collections agencies and hospital business office collection personnel. This application should be completed by the collection agency Vice President, Director or Manager who will sever as the voting member of the agency. Please complete the following information, attach your check for the New Member processing fee and first year membership dues and mail to the address below.

Your application will be presented to the Board of Directors at the next meeting for approval. Thank you for your interest in the NHCA.

### Agency Information:

Agency Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_

Website Address: \_\_\_\_\_

Healthcare Parent: \_\_\_\_\_  
Corporation

Date Agency: \_\_\_\_\_ Number of Hospitals Served: \_\_\_\_ Profit \_\_\_\_ Not For Profit \_\_\_\_  
Incorporated

### Member Information:

Circle One

Regular/Associate, Member Name: \_\_\_\_\_ Title: \_\_\_\_\_

Only one Regular Member per agency

Unlimited number of Associate memberships available.

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Your Email Address: \_\_\_\_\_ Years in Healthcare collections: \_\_\_\_\_

Please attach any marketing information or website information that will help us understand your agency better.

I certified that the agency submitting this application for membership is owned by a healthcare organization.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Please Print Your Name)

New member Applications Fee:	\$ <u>100.00</u>	(New Regular membership only)
Annual Membership Dues if Agency has 10 or Less FTE's: \$ 350.00	\$ _____	
Annual Membership Dues if Agency has 11+ FTE's: \$ 450.00	\$ _____	
Additional Members (Associate) ea. @ \$ 125.00 <i>Attach additional copies for each</i>	\$ _____	
Total Enclosed	\$ _____	

Mail to: NHCA/Membership, 1502 Williamson RD. NE Suite 100, Roanoke, VA. 24012