HOMES Membership Enrollment Form

Please mail this form with payment, or fax to (866) 466-3190

HOMES
515 Kempton St.
New Bedford, MA 02740

Date: _____ ☐ New Registration ☐ Renew Registration

Company Name: _____

Mailing Address:_____ PO Box: _____

Phone: _____ Fax: _____

Main Contact Name: _____ Title: _____

Main Email: _____

Secondary Contact Name: _____ Title: _____

Secondary Email: _____

Website: _____

Additional Email Contacts (billing management and/or billing staff recommended):

_____

∞ HOMES Membership Level and Annual Dues ∞

► **What is your annual revenue range?**

Revenue	Membership Level	HOMES Annual Dues
☐ Annual revenue more than $10,000,000	4	$1,500
☐ Annual revenue $5,000,000 - $10,000,000	3	$1,375
☐ Annual revenue $1,000,000 - $5,000,000	2	$1,175
☐ Annual revenue up to $1,000,000	1	$575

► **Additional state location memberships:**

☐ CT ☐ MA ☐ ME ☐ NH ☐ RI ☐ VT

$125.00 per each additional state location. Example: If your corporate office is in Maine, and you have an additional branch in New Hampshire, please add $125 to your initial dues payment and fill out page 3 of this registration: Addition State Location Memberships Information.

► **Total number of locations:**

☐ 1 ☐ 2-5 ☐ 6-10 ☐ More than 10

∞ General Information ∞

(All information provided is kept strictly confidential)

► **What HME products do you provide?**
(Check all that apply)

☐ Durable Medical Equipment
☐ Respiratory/Oxygen
☐ Complex Mobility/Assistive Technology
☐ Medical Supply/Disposables
☐ Home Infusion

Other (specify): _____

► **I have a retail store:** ☐ Yes / ☐ No

► **I am a Medicaid provider:** ☐ Yes / ☐ No

► **I have a Medicaid provider number in these states:**

☐ CT ☐ NH
☐ ME ☐ RI
☐ MA ☐ VT

HOMES Membership Enrollment Form

HOMES
Home Medical Equipment and Services Association of New England

► Number of staff: (#) _____

► Name of accrediting organization:

_____

► I am a member of the following associations:

☐ AAHomecare
☐ NCART
☐ The VGM Group
☐ The MED Group

► Number of Medicare beneficiaries served: (#) _____

► Number of Medicaid beneficiaries served: (#) _____

► Percentage of non-insured clients: _____%

► List legislative district:

_____ (State) _____ (District #)

ꕥMembership Dues ꕥ

Membership Level:

☐ Level 4 - $1,500
☐ Level 3 - $1,375
☐ Level 2 - $1,175
☐ Level 1 - $575

Number of additional membership locations (if any): _____ x $125 = $ _____

***New Members: 25% Off**

Dues Total: $ _____

ꕥPayment Method ꕥ

☐ Check enclosed made payable to HOMES, 515 Kempton Street, New Bedford, MA 02740

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

Credit Card No.:_____ Expires: _____/_____

Name on Card: _____ Security Code: _____

Email Receipt To: _____ Zip Code: _____

CERTIFICATION – By the signature affixed below, I hereby certify that the information submitted in this application is true, complete and correct to the best of my knowledge. I acknowledge that I have read and understood the HOMES Code of Ethics (see back) and agree to conduct my business in accordance with its principles. I also understand that my membership in HOMES may be terminated for failure to comply with the principles enumerated in the HOMES Code of Ethics.

Signature: _____ Date: _____/_____/_____

HOMES
Home Medical Equipment and Services Association of New England

HOMES Membership Enrollment Form

☙ Additional State Locations Memberships Information ❧

State: ☐ CT ☐ MA ☐ ME ☐ NH ☐ RI ☐ VT
Address: ______________________________
Phone: ______________________________
Main Contact Name: ______________________________
Main Email: ______________________________

State: ☐ CT ☐ MA ☐ ME ☐ NH ☐ RI ☐ VT
Address: ______________________________
Phone: ______________________________
Main Contact Name: ______________________________
Main Email: ______________________________

State: ☐ CT ☐ MA ☐ ME ☐ NH ☐ RI ☐ VT
Address: ______________________________
Phone: ______________________________
Main Contact Name: ______________________________
Main Email: ______________________________

State: ☐ CT ☐ MA ☐ ME ☐ NH ☐ RI ☐ VT
Address: ______________________________
Phone: ______________________________
Main Contact Name: ______________________________
Main Email: ______________________________

State: ☐ CT ☐ MA ☐ ME ☐ NH ☐ RI ☐ VT
Address: ______________________________
Phone: ______________________________
Main Contact Name: ______________________________
Main Email: ______________________________

HOMES
Home Medical Equipment and Services Association of New England

Code of Ethics

The purpose of the Code of Ethics shall be to set and improve standards within the practice of providing home medical equipment and services. To maintain the ethical conduct and integrity of this Association, a member pledges to abide by the following:

1. To render the highest level of care promptly and competently, taking into account the health and safety of the patient.

2. To serve all patients regardless of race, creed, national origin, or reason of illness.

3. To provide quality home medical equipment and services which are appropriate for the patient's needs and to never knowingly condone or assist the dispensing, promoting or distributing of medical devices or services which are not good quality, or which lack therapeutic value for the patient.

4. To instruct the patients and/or caregivers in the proper use of the equipment.

5. To explain fully and accurately to patients and/or caregivers the patient's rights and obligations regarding the rental, sale, and service of home medical equipment.

6. To respect the confidential nature of the patient's records and not to disclose such information without prior authorization, except as required by law.

7. To continue to expand and improve professional knowledge and skills so as to provide patients with equipment and services which are continually updated.

8. To abide by both federal and local laws and regulations which govern the home medical equipment industry and to accept these ethical principals; not to engage in any activity that will bring discredit to this business field; and expose, without fear or favor, illegal or unethical conduct.

9. To avoid participating, directly or indirectly, with a source of patient referrals in a "captive referral arrangement," whereby patients are directed to utilize a supplier of home medical equipment in derogation of the patient's rights to select the suppliers of their choice.

10. To act in good faith; to be honest, truthful and fair to all concerned, and to hold the health and safety of patients as first consideration, promptly rendering to each patient the full measure of his or her ability.