Inspire Collaborative Health Association

Provider Membership Enrollment

Personal Information

Full Name: ______________________________ Date: __________

Last *First* *M.I.*

Home Address: ______________________________

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Personal Phone: ______________ Personal Email: ______________

Work Information

Place of employment[1]:		Work Address[1]:	
Office Phone[1]:		Work Website[1]:	
Designations[1] (MD, NP, etc.)		Specialty[1]:	

Are you the owner/operator/manager of this business?	☐ YES	☐ NO

If Yes, answer the following four questions.

Business Establishment Date:		Is the business in compliance with all local, state, and federal requirements? [2]	☐ YES	☐ NO

Does the business carry a current/active form of liability insurance?	☐ YES	☐ NO	In addition to, or instead of business liability, do you carry a personal policy that covers you in your scope of practice?	☐ YES	☐ NO

[1] How you'd like it listed on the website member directory card. [2] Specifically, licensing requirements.

Directory Preferences

Are you currently accepting new patients/clients?	☐ YES	☐ NO

If NO, you will still be listed in our directory, but your new patient “closed” status will be notated.

Can we post your picture in our directory?	☐ YES	☐ NO
Would you like us to use a headshot/photo from your current employer's website?	☐ YES	☐ NO
Would you prefer to supply a picture?	☐ YES	☐ NO
There is a place for you to summarize to site visitors why you chose to join ICHA, your personal vision or mission, or a little bit about yourself. Would you like to make a statement that we could use next to your picture and contact information? (500 characters or less)	☐ YES	☐ NO

If yes, please make a statement here:

Disclaimer and Signature

The personal information supplied here will never be made public or sold for solicitation and is shared here only for the use of communication directly from the association regarding dues, events, or publications. The Member Directory will share your work details only. By signing this document, you acknowledge and approve your work information to be listed on the Inspire Collaborative Health Association website for the potential use of patients/clients to contact you for services.

I certify that my answers are accurate and complete to the best of my knowledge. By signing this document, I understand that I am becoming an active member of the Inspire Collaborative Health Association and acknowledge my information will be listed in the member directory. I understand features, benefits, and co-members are subject to change as ICHA grows and develops.

Signature:		Date:	

Membership Assistance

Inspire Collaborative Health Association never wants a qualified health professional interested in our mission to miss out on the opportunity to join due to cost. Donations make it possible for us to offer assistance to professionals who qualify. Membership assistance comes in the form of a discount. Three tiers of discounts are available. Tier 1 = 15% discount. Tier 2 = 25% discount. Tier 3 = 35% discount.

Are you interested in applying for membership assistance?	☐ YES	☐ NO

If yes, please fill out the included Membership Assistance Application in this packet and submit it along with the rest of your enrollment paperwork. Debit or credit card information should still be included below but will not be charged until the applicant is notified of the approved discount. The discount applies towards one annual membership due and will need to be reevaluated with an updated application one month before membership renewal the following year.

Payment and Authorization

Please complete all fields. Cancellation of auto-renewal membership dues must be submitted at least one month before the annual renewal date; cancellation requests made within one month of your renewal date will be processed for the following year's membership. This authorization will remain in effect until a written cancellation is received. Annual dues and donations can not be refunded.

Reminder: Your membership dues and any donations are tax-deductible.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other
Cardholder Name (as shown on card): ________________________________
Card Number: ________________________________ CVV: ______________
Expiration Date (mm/yy): ____________________________
Cardholder ZIP Code (from credit card billing address): __________________

I,______________________________, authorize Inspire Collaborative Health Association to charge my credit card for annual membership dues in the amount of

☐ $700.00 (Standard Rate) ☐ $595.00 - $455.00 (Tiered Rate-if approved for membership assistance)

I understand that my payment information can be saved on file for future transactions (annual dues or authorized donations) on my account.

☐ Yes, save my card and auto-renew my dues each year. ☐ No, do not save my card for auto-renewal.

Signature:		Date:	

Would you like to make a one-time or recurring donation to help the growth, development, and mission of ICHA? This donation will help fund the recruitment of more providers, practitioners, and strategic partners, as well as the association as a whole for future banquets, seminars, and services. All donations are tax-deductible.

☐ Yes, please accept a donation of $_____________.

☐ One-time donation ☐ Repeat donation ☐ Frequency: ____________

☐ No, not at this time.

Signature:		Date:	

Thank you for applying to become a Member of Inspire Collaborative Health Association. Once approved, we will process your payment and issue you a personalized membership certificate. Within two weeks of approval you will receive a welcome packet containing marketing materials and association information . Your information will be listed in our member directory, and you will have access to all other benefits. Additionally, as they become available, you can expect future details on annual member banquets, classes, seminars, discounts, and other member perks. We are very excited to have you a part of our association, and we look forward to what we can accomplish together.

*In some cases, we may determine that a professional's experience or scope of practice does not align with ICHA's requirements. Should this happen, we will refund your payment or proceed not to process your payment, and we will securely destroy and dispose of your payment information. You will then receive a letter of decline. In this scenario, applicants are welcome to reapply in the future should their experience or credentials change from their original application.

**For enrollments that include a Membership Assistance Application, ICHA will review the information and make a discount determination within two weeks. Once completed, ICHA will contact you to notify you of your annual dues amount and confirm payment.

***Submission of enrollment & payment information is not a guarantee of member or partnership status. All enrollment information will be reviewed by ICHA. Payments are only processed and retained for those who meet ICHA standards. Should a business or individual submit enrollment that does not meet these standards and payment has been submitted, their payment will be returned in full.

Inspire Collaborative Health Association

Membership Assistance Application

Personal Information							
Name:				Phone:			
Address:		City:		ST:		Zip:	
Email:							

Income		Expense	
Gross Monthly Income (Before Taxes)	$	Rent/Mortgage	$
Spouse's Gross Monthly Income (Before Taxes)	$	Car/Insurance	$
Child Support	$	Fuel	$
Aid To Dependent Children	$	Groceries	$
Social Security Compensation	$	Utilities	$
Unemployment Compensation	$	Phone	$
Food Stamps	$	Child Support	$
Welfare	$	Medical	$
Retirement Funds	$	Child Care	$
Other (Please Explain)	$	Alimony	$
Other (Please Explain)	$	Other (Please Explain)	$
TOTAL MONTHLY INCOME:	$	**TOTAL MONTHLY EXPENSE:**	$

The following may be used to support your financial assistance request:

☐ 1040 Tax Form	☐ Free & Reduced Lunch Letter	☐ Social Security Letter

Additional Items For Consideration (Job Loss, Disability, etc.)

I am requesting assistance from ICHA due to my current personal circumstances. I verify that all information submitted is complete and accurate. If my situation changes, I agree to notify ICHA. If I submit false or inaccurate information, my current and future enrollments could be subject to denial.

I understand that if approved, my membership assistance discount covers one years annual membership due. To extend this discount into next year's annual membership due, I must re-verify my income one month before the end of my annual renewal period.

Applicant Signature: ______________________________ Date: ______________

Assistance Approval (Internal Use for ICHA Staff Only)							
Approved By:		Date:		Approved Discount:	☐ 15%	☐ 25%	☐ 35%