

2010 PPAT MEMBERSHIP APPLICATION

Please complete both pages of this application and return with payment to the PPAT Office. PPAT retains the right to verify all information provided on this application.

GENERAL INFORMATION

Company/Organization: _____

Contact: _____ **Title:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: () _____ **Fax Number:** () _____

E-mail: _____ **Website:** _____

Remember: As a member benefit, PPAT provides links to members' websites on its webpage so families and consumers can access your programs and services. Please know that this list of providers is a popular destination on our website.

REGULAR MEMBERSHIP –In accordance with the bylaws, all beds/persons served in ICF/MR, HCS, and TxHmL must be reported and paid for to be a member in good standing.

I. ICF/MR and HCS. Complete all information below:

_____ Total # of ICF/MR beds

_____ Total # of persons served in HCS

_____ Total Number

Total Dues Payable \$ _____

DUES:

- 11 or less beds/persons served: \$750.00
- More than 11 beds/persons served:
 - First 300: \$65.00 per bed/person
 - Over 300 but less than 501: *plus* \$45.00 per bed/person
 - Over 501 but less than 1001: *plus* \$30.00 per bed/person
 - Over 1001: *plus* \$25.00 per bed/person

II. TxHmL - Complete all information below:

_____ Total # of TxHmL persons served

Total Dues Payable \$ _____

DUES:

- \$15.00 per person

TOTAL DUES and FEES

\$ _____ ICF/MR and HCS Dues Payable
\$ _____ TxHmL Dues Payable
\$ _____ Outstanding Fees Owed
\$ _____ Total Amount Owed
\$ _____ Total Amount Enclosed
\$ _____ BALANCE DUE

NOTE: Contributions and gifts to the Association are not deductible as charitable contributions for federal income tax purposes. Payments of membership dues are deductible for most members under Section 162 of the Internal Revenue Code as an ordinary and necessary business expense. For CY 2010 we have estimated that 20% of a member’s dues are non-deductible.

METHOD OF PAYMENT - Please check one:

_____ **Full Dues Enclosed**
_____ **Will pay over a three (3) consecutive month plan.**
Request payment schedule as follows:
Date: _____ **Payment Amount:** \$ _____
Date: _____ **Payment Amount:** \$ _____
Date: _____ **Payment Amount:** \$ _____

TYPE OF PAYMENT

Checks: Make checks payable to PPAT
Credit Card: Visa or MasterCard (Circle One) Expiration Date: _____
Credit Card #: _____
Name on Credit Card: _____
Signature: _____

Note: Credit Card payments will be automatically charged on the scheduled payment plan date.

Forward your completed application with payment by January 22, 2010 to:
Private Providers Association of Texas
8711 Burnet Road, Suite E-53 • Austin, TX 78757
512-452-8188 • Fax 512-458-3078 • ppat100@aol.com • www.ppat100.com