MEMBERSHIP INFORMATION FORM

F.A.F.C.H.A.

(Florida's Adult Family Care Home Association)

Dues: 7/1/10 - 6/30/11 - $33 per licensed bed
Please fill out one application per home

Provider Contact Information

License #		Number of Beds:	
Provider Name	**Spouse**		
AFH Name			
AFH Mailing Address	City	Zip	County
Provider Address (If different)	City	Zip	County
Phone	**Fax**		
Email Address			
Website Address			
Signature		**Date**	

☐ Enclosed **is my check for membership in the amount of $**_____

OR

Charge my membership in the amt of $_____ **to:** ☐ **VISA** ☐ **Master Card** ☐ **American Express**

Account # | | | | | - | | | | | - | | | | | - | | | | **Expiration Date** ____/____

Security Code _____ (the last three numbers in or beside the signature panel on the back of your card)

Name as shown on the card _____

Signature _____ **Date** _____

For Office Use ONLY

Check # _____ Check Date _____ Date Received _____ Amount $ _____

Membership Year_____Membership Number_____

CC Auth Number _____ Cert Sent _____

Mail this form with your payment to:
F.A.F.C.H.A. - 10579 101st Ave.
Seminole, FL. 33772-2502 or
Fax this form to (509) 461-4867
Please visit our Website at CareHomeFLA.com