



JAMES

Keeping Members Informed

JERSEY ASSOCIATION OF MEDICAL EQUIPMENT SERVICES

The Jersey Association of Medical Equipment Suppliers (JAMES) was established to disseminate information to Durable Medical Equipment Suppliers (DME). The following is a short list of Membership benefits:

- ANNUAL CONVENTION
- ELECTRONIC ALERT – This emailed publication “alerts” you to the most up-to-date industry information.
- EDUCATIONAL SEMINARS – Designated to assist you in marketing, billing, purchasing and management.
- REPRESENTATION ON A STATE AND FEDERAL LEVEL: The Association represents its members with all federal and state programs. Lobbying is scheduled once a year in Washington.

APPLICATION FORM

COMPANY NAME (please print or type clearly on above line) MEDICAID # MEDICARE #

DOING BUSINESS AS

NAME OF COMPANY PRESIDENT OR CEO NAME & EMAIL ADDRESS OF PERSON TO RECEIVE ALERTS

ADDRESS CITY STATE ZIP

PHONE FAX E-MAIL

ARE YOU A SUBSIDIARY OF ANOTHER COMPANY? _____

IF YES, PLEASE GIVE THE FOLLOWING INFORMATION:

PARENT COMPANY NAME NAME OF PRESIDENT OR CEO

ADDRESS OF PARENT COMPANY CITY STATE ZIP

PHONE FAX E-MAIL

HAVE YOU OPERATED AS AN HME AND RELATED SUPPLIES COMPANY UNDER ANOTHER CORPORATE NAME? _____

HAVE YOU HAD A PREVIOUS MEDICARE, MEDICAID #: _____ IF YES, THE NUMBER: _____

IF YES, PLEASE LIST THE CORPORATE NAMES(S) AND LOCATIONS(S):

COMPANY NAME

ADDRESS CITY STATE ZIP

COMPANY NAME

ADDRESS CITY STATE ZIP

BRANCH LOCATION(S): To be completed by Parent Company Only. Please list any branch offices:

BRANCH - COMPANY NAME BRANCH MANAGER

ADDRESS CITY STATE ZIP

PHONE FAX E-MAIL

(ATTACH ADDITIONAL SHEETS IF NEEDED FOR ADDITIONAL BRANCH LOCATIONS)

1. TO THE BEST OF YOUR KNOWLEDGE, HAVE YOU, YOUR CURRENT OR PRIOR COMPANY(IES) OR ANY OF YOUR OFFICERS, MANAGERS OR OWNERS BEEN INVESTIGATED WITHIN THE LAST FIVE YEARS FOR MEDICARE OR MEDICAID FRAUD AND ABUSE OF FALSE CLAIMS? _____ YES _____ NO

2. TO THE BEST OF YOUR KNOWLEDGE, HAVE YOU BEEN AN OWNER OR A MANAGING EMPLOYEE OF OR HELD A FINANCIAL INTEREST IN ANY BUSINESS THAT HAS BEEN ASSESSED A CIVIL MONEY PENALTY FOR AND/OR HAS BEEN CONVICTED OF MEDICARE OR MEDICAID FRAUD AND ABUSE OF FALSE CLAIMS? _____ YES _____ NO

3. TO THE BEST OF YOUR KNOWLEDGE, HAVE YOU EVER BEEN AN OWNER OR MANAGING EMPLOYEE OF OR HELD A FINANCIAL INTEREST IN ANY BUSINESS THAT HAS BEEN CONVICTED OF VIOLATING OTHER FEDERAL, STATE OR LOCAL LAWS OR REGULATIONS RELATING TO HEALTH CARE? _____ YES _____ NO
IF YOU ANSWERED "YES" TO (1), (2) OR (3), PLEASE ATTACH A FULL EXPLANATION OF THESE REASONS FOR THE INVESTIGATION, THE RESULT OF THE INVESTIGATION AND ANY OUTCOME. A "YES" ANSWER MAY NOT NECESSARILY PRECLUDE ACCEPTANCE AS A MEMBER, BUT WILL REQUIRE THAT YOUR APPLICATION BE GIVEN AN EXTENDED REVIEW. ALL WRITTEN EXPLANATIONS WILL BE KEPT CONFIDENTIAL TO PERSONS DIRECTLY INVOLVED IN THE APPLICATION REVIEW PROCESS.

PLEASE SELECT TYPE OF BUSINESS:

___ SOLE PROPRIETOR (OWNER) ___ PARTNERSHIP ___ DISTRIBUTOR
___ REGIONAL CHAIN ___ NATIONAL CHAIN ___ PHARMACY
___ HOSPITAL BASED ___ NURSING HOME ___ HMO
___ OTHER: _____

PLEASE RATE YOUR COMPANY'S TOP REVENUE PRODUCERS IN NUMERICAL ORDER:

___ DME ___ OXYGEN ___ PEN
___ DISPOSABLES ___ REHABILITATION ___ OTHER: _____

MEMBERSHIP CLASSIFICATION

GENERAL: A SOLE PROPRIETORSHIP, PARTNERSHIP, FIRM OR CORPORATION CURRENTLY ENGAGED IN THE RETAIL/WHOLESALE, RENTAL OR DISTRIBUTION OF ANY TYPE OF MEDICAL EQUIPMENT, PRODUCTS, SERVICES OR SUPPLIES FOR HOME USE IN THE CARE AND TREATMENT OF PATIENTS, A REGULAR MEMBER SHALL HAVE FULL VOTING RIGHTS.

ASSOCIATE: A PERSON, PARTNERSHIP, FIRM OR CORPORATION NOT OTHERWISE QUALIFIED FOR REGULAR MEMBERSHIP THAT ENGAGES, THROUGH MANUFACTURING, WHOLESALE, OR OTHERWISE IN A BUSINESS THAT SUPPORTS OR ENHANCES A REGULAR MEMBER'S HEALTH CARE BUSINESS.

PAYMENT METHOD

GENERAL MEMBERSHIP: PLEASE ENCLOSE YOUR CHECK IN THE AMOUNT OF \$500.00 WITH THIS APPLICATION. UPON THE APPROVAL OF THIS APPLICATION YOU WILL BE BILLED AN ADDITIONAL \$500.00. APPLICATIONS FOR MEMBERSHIP ARE REVIEWED BY THE BOARD OF DIRECTORS ON A MONTHLY BASIS. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO CONTACT WENDY RUSSALESI, EXECUTIVE DIRECTOR AT 732-503-5665.

ASSOCIATE MEMBERSHIP: PLEASE ENCLOSE YOUR CHECK IN THE AMOUNT OF \$425.00 WITH THIS APPLICATION. APPLICATIONS FOR MEMBERSHIP ARE REVIEWED BY THE BOARD OF DIRECTORS ON A MONTHLY BASIS, UPON APPROVAL YOU WILL BE BILLED AN ADDITIONAL \$425.00. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO CONTACT WENDY RUSSALESI, EXECUTIVE DIRECTOR AT 732-503-5665.

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 AND BELIEF. I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THE JAMES CODE OF ETHICS AND AGREE TO CONDUCT MY BUSINESS IN ACCORDANCE WITH ITS PRINCIPLES. I ALSO UNDERSTAND THAT MY MEMBERSHIP IN JAMES MAY BE TERMINATED FOR FAILURE TO COMPLY WITH THE PRINCIPLES ENUMERATED IN THE CODE OF ETHICS.

JAMES RESERVES THE FOLLOWING RIGHTS: TO DENY ANY MEMBERSHIP APPLICATION; TO NOT RENEW A MEMBERSHIP; AND TO TERMINATE ANY MEMBERSHIP FOR THE CAUSE IN ACCORDANCE WITH THE PROCEDURES CONTAINED IN THE JAMES BYLAWS.

AUTHORIZED SIGNATURE: _____
DATE: _____

RETURN THIS FORM ALONG WITH CHECK TO:

J A M E S
Attn: Membership
PO BOX 38
Jackson, NJ 08527

732-503-5665 Fax 732-833-2029

Referred for Membership by: _____

For Office Use Application Status: _____ Date: _____
