Infection Surveillance Project
Agency Enrollment Form and Participation Agreement

Company Name_____

Company Address_____

City_____State_____ Zip_____

Phone_____Fax_____

Project Manager_____Title_____

Email_____

Alternate Contact_____Title_____

Email_____

□ I have read the Guidelines and Policies document and the Quality Assurance Procedures and I agree to comply with the terms and requirements therein.

Project Supervisor's Signature_____Date_____

Demographic Information for the Most Recent Calendar Year
To ensure accuracy of data comparisons, please complete this demographic information.

1. **Home Health Agency Base**

   [ ] Freestanding [ ] Institutional

2. **Designation**

   [ ] Urban [ ] Rural

3. **The total number of visits per year** _____

Project Participation Fees: $200.00 Enrollment fee *(due first year only)*
$400.00 Annual fee

Enclosed: $_____

Return this completed, signed agreement with the first annual payment to:

***Missouri Alliance for* HOME CARE**
2420 Hyde Park, Suite A, Jefferson City, MO 65109-4731 ▪ (573) 634-7772 ▪ (573) 634-4374 Fax
www.homecaremissouri.org