



PRIVATE PROVIDERS ASSOCIATION OF TEXAS
2025 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. You can complete this form with Adobe Reader or print and complete.

GENERAL INFORMATION

Company/Organization: _____
Providers' NPI#: _____
Contact: _____ Title: _____
Address: _____ City: _____ ST: _____ ZIP: _____
Phone Number: _____ Fax Number: _____
E-mail: _____ Website: _____



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

I. ICF and HCS - Complete all information below:

_____ Total # of ICF 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 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 2025 we have estimated that 15% 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

Payment Information:

\$ _____ TOTAL PAYMENT ENCLOSED

Check (Please make payment payable to PPAT)

Credit Card: American Express Discover MasterCard VISA

Credit Card #: _____ Exp. Date: _____

Credit Card Holder Name: _____ CVV: _____

Credit Card Holder Signature: _____

Note: Personal or digital signature required to process applications using a credit card. (In Adobe Acrobat tools menu click on "Fill & Sign". Complete requested information. You will be prompted to add your digital ID/signature. You can create a secure digital ID/signature by following the on-screen instructions. After completion, save to your computer and email to PPAT. For non-digital signatures - after completion, print, sign & fax to PPAT.)

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



Forward your completed application with payment by **January 31, 2025** to:

Private Providers Association of Texas
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512-452-8188 • Fax 512-458-3078 • ppatt100@aol.com • www.ppat200.com