

2010 COUNTY PROVIDER MEMBER DUES APPLICATION



Agency Name (Home Care Parent) _____

Address _____

City/State/Zip _____

Main Phone _____

Fax _____

Website _____

CEO/Authorized Representative _____

Direct Phone _____

Email _____

Annual Dues

PLEASE SELECT ONE OF THE FOLLOWING THREE PACKAGES FOR HCA MEMBERSHIP/DUES

Package One - Full HCA Membership

Under this package County (Sponsored) Programs will pay dues based on patient revenue and the corresponding dues level (see structure below). Benefits include all member benefits, publications, and services provided by the Association, as well as some enhanced (County Only) benefits both of which include:

- o Communications (ASAP, E-lets, and other publications)
- o An additional 15% discount on ALL HCA education programs and attendance at HCA Free Programming
- o Two for one registration at our signature events (Annual Meeting, Senior Financial Managers Conference and Clinical and Technology Conference)
- o Staff/Technical Assistance on pressing policy issues
- o Assistance with locating alternative-priced accommodations when attending multi-day workshops

HCA dues are for a calendar year, based on the agency's **total home care patient revenue** reported from your most recently completed fiscal year. If an agency has affiliated entities, the agency must add the revenue of **all** affiliates to the agency's revenues to determine the total home care patient revenue. **Mandatory inclusion of the agencies audited, consolidated, financial statement, including the functional schedule (related to home care) must be included with this application. HCA will not disclose this information for any purpose to any party outside of the Association.**

Certificate #	Patient Revenue	Agency Name	NYS Operating
CHHA	\$ _____	_____	_____
LTHHCP	\$ _____	_____	_____
LHCSA	\$ _____	_____	_____
Home Attendant	\$ _____	_____	_____
MLTC/PACE	\$ _____	_____	_____
Hospice	\$ _____	_____	_____
Other Affiliates	\$ _____	_____	_____

Total Revenues: \$ _____

Total Patient Revenue Scale

- \$150,000,001 or greater
- \$50,000,001 to \$150,000,000
- \$30,000,001 to \$50,000,000
- \$21,000,001 to \$30,000,000
- \$11,000,001 to \$21,000,000
- \$6,000,001 to \$11,000,000

Dues Amount

- \$40,500
- \$25,500
- \$16,500
- \$14,500
- \$12,500
- \$11,500

Total 2010 Dues \$ _____

Below \$6,000,000 – Use this formula

$$.00174 \times \frac{\text{\$ Total Patient Revenue}}{\text{Total Patient Revenue}} = \frac{\text{\$ Total Dues Amount}}{\text{Total Dues Amount}}$$

If the "Total Dues Amount" is **less** than **\$2,500.00**, your agency's dues are **\$2,500.00 otherwise** your agency dues are the final calculation amount in the "Total Dues Amount."

Package Two - Subscription and Communication Membership

Under this package County (Sponsored) Programs will pay \$1,250.00 in annual dues (regardless of patient revenue) Benefits **include and are limited** to the following:

- o Access to HCA communications and publications (such as ASAP, E-lets, membership directory) and a listing in the 2010/2011 HCA Membership and Resource Directory
- o Attendance at any free HCA sponsored educational programming (i.e. Membership Forums, Regional Meetings, Budget Briefing Audio-Conferences)

Package Three - Subscription Membership

Under this package County (Sponsored) Programs will pay \$1,000.00 in annual dues (regardless of patient revenue) Benefits **include and are limited** to the following:

- o Access to HCA communications and publications (such as ASAP, E-lets, membership directory)

Our Agency _____ selects the following Membership Package for 2010

- Package One – FULL MEMBERSHIP (patient revenue and dues are indicated above and below)
- Package Two – SUBSCRIPTION and COMMUNICATIONS MEMBERSHIP \$1,250.00
- Package Three – SUBSCRIPTION MEMBERSHIP only \$1,000.00

Total 2010 Dues \$ _____

I certify that the above revenue information is true and correct:

Authorized Signature Title (CEO, Administrator or CFO) Date

Method of Payment

- Charge the full amount to credit card Visa Mastercard American Express Discover

Card Number Expiration Date

Printed Name Authorized Signature

- Check will follow for the full amount payable to Home Care Association of NYS
- Pay dues on a quarterly basis. Please note **you will only receive ONE invoice but will receive a quarterly statement as a reminder.**

Please fax your application to the renewal fax line at 518.426.8788 or mail to the address below.

Home Care Association of New York State