

2010 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

HCA Provider 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.**

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

Total Patient Revenue Scale

- | | |
|---|----------|
| <input type="checkbox"/> \$500 Million or greater | \$45,000 |
| <input type="checkbox"/> \$250 Million to \$499,999,999 M | \$43,500 |
| <input type="checkbox"/> \$150 Million to \$249,999,999 M | \$42,500 |
| <input type="checkbox"/> \$100 Million to \$149,999,999 M | \$28,500 |
| <input type="checkbox"/> \$75 Million to \$99,999,999 M | \$28,500 |
| <input type="checkbox"/> \$60 Million to \$74,999,999 M | \$27,500 |
| <input type="checkbox"/> \$50 Million to \$59,999,999 M | \$26,500 |
| <input type="checkbox"/> \$40 Million to \$49,999,999 M | \$18,000 |

Continued on next column

Total 2010 Dues \$ _____

Total Patient Revenue Scale

- | | |
|---|----------|
| <input type="checkbox"/> \$30 Million to \$39,999,999 M | \$17,500 |
| <input type="checkbox"/> \$20 Million to \$29,999,999 M | \$15,250 |
| <input type="checkbox"/> \$10 Million to \$19,999,999 M | \$14,000 |
| <input type="checkbox"/> \$5 Million to \$9,999,999 M | \$12,500 |

Below \$5,000,000 Million – Use this formula
 $.00188 \times \$ \underline{\hspace{2cm}} = \$ \underline{\hspace{2cm}}$
Total Patient Revenue Total Dues Amount
If the "Total Dues Amount" is less than \$2,750.00, your agency's dues are \$2,750.00.

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