

Agency Name: _____

CEO/Authorized Rep: _____

Address: _____

City/State/Zip: _____, _____

Email/Direct Phone: _____

Main Phone/Fax: _____

National vendors that are selling a product or service to home care agencies should use **HCA's Vendor Application**. **Associate Members** include firms or companies that support home care agencies, such as consulting, legal or financial services.

Individual Roles and Contact Information

A list of roles has been established to ensure that the information HCA sends out is forwarded to the appropriate contact person. Please note that one staff person may be the contact for multiple roles listed below.

ROLES	DESCRIPTION
Main Contact	List the person whom you want to be the main contact from your company - limited to one person .
Directory Contact	List the person whom you want printed in the HCA Membership Directory - limited to one person .
Billing Contact	List the person who should receive billing information - limited to one person .

Please check if applicable:

- Main (only 1 person)
- Directory (only 1 person)
- Billing (only 1 person)
- Address same as above**

Name: _____

Title: _____

Direct Line: _____ Fax: _____

Email: _____

Mailing Address: _____

Please check if applicable:

- Main (only 1 person)
- Directory (only 1 person)
- Billing (only 1 person)
- Address same as above**

Name: _____

Title: _____

Direct Line: _____ Fax: _____

Email: _____

Mailing Address: _____

Please check if applicable:

- Main (only 1 person)
- Directory (only 1 person)
- Billing (only 1 person)
- Address same as above**

Name: _____

Title: _____

Direct Line: _____ Fax: _____

Email: _____

Mailing Address: _____

Please check if applicable:

- Main (only 1 person)
- Directory (only 1 person)
- Billing (only 1 person)
- Address same as above**

Name: _____

Title: _____

Direct Line: _____ Fax: _____

Email: _____

Mailing Address: _____



Associate Member Dues Application - 2016



Services Provided

Please check the categories below that you would like your company listed under in the HCA's membership directory.

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Services | <u>Disease Management</u> | <input type="checkbox"/> Medical Disposal Products |
| <input type="checkbox"/> Answering Service | <input type="checkbox"/> CHF | <input type="checkbox"/> Medical Product Supplier |
| <input type="checkbox"/> Billing/Information Systems | <input type="checkbox"/> COPD | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Dementia/Cognitive Issues | <input type="checkbox"/> Outcome Measurement |
| <input type="checkbox"/> Certified Public Accounting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Personal Emergency Response System |
| <input type="checkbox"/> Claims Management | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Pharmacy / Pharmaceutical Supplies |
| <input type="checkbox"/> Computer Hardware | <input type="checkbox"/> Maternal / Child Health | <input type="checkbox"/> Physical Therapy |
| | <input type="checkbox"/> Mental Health | <input type="checkbox"/> PRI / Screen Assessments |
| <u>Consulting</u> | <input type="checkbox"/> Wound Care | <input type="checkbox"/> Publications |
| <input type="checkbox"/> Education | <input type="checkbox"/> Documentation/Nursing Process | <input type="checkbox"/> Quality Improvement |
| <input type="checkbox"/> HIPAA | <input type="checkbox"/> Durable / Home Medical Equipment | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Licensure/Start-up | <input type="checkbox"/> Employment & Benefits | <input type="checkbox"/> Scheduling |
| <input type="checkbox"/> Managed Care | <input type="checkbox"/> Executive Search | <input type="checkbox"/> Software Supplier |
| <input type="checkbox"/> Management | <input type="checkbox"/> Financial Services | <input type="checkbox"/> Telehealth |
| <input type="checkbox"/> Nursing Practice/Clinical | <input type="checkbox"/> Insurance | <input type="checkbox"/> Telephony |
| <input type="checkbox"/> OASIS | <input type="checkbox"/> IV Therapy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Risk Management | <input type="checkbox"/> Legal Services | |
| <input type="checkbox"/> Training | | |

Product/Services Description:

Please provide a 30 word or less description of your products/services to be listed in our printed materials for our trade shows or other publications. Please type or print clearly. If necessary, attach a separate piece of paper with your description.

Payment Information

Associate Member

As an associate member you will receive the following benefits:

- Discounted booth rates for HCA's signature events;
- Advance opportunity to secure exhibit and sponsorship opportunities;
- Your company will also be listed on HCA's website;
- Access to the Members Only section on our website;
- HCA's weekly newsletter, the *Situation Report* and select policy and information e-lets;
- Discounted advertising rates and sponsorship opportunities throughout the year;
- Access to HCA education programs, with opportunities to interact and network with members, and possibly serve as faculty; and
- Discounted booth rates for HCA's signature events.

Please select one:

- Associate Member Organization
with Annual Budget Over \$250,000 \$3,600
- Associate Member Organization
with Annual Budget Under \$250,000 \$1,550

Total: \$ _____

Pay by Credit Card:

Charge the full 2017 Associate Membership Dues amount indicated above to credit card:

- VISA MasterCard American Express Discover
-

Card Number _____ Expiration Date _____ Security Code _____

Printed Name _____ Authorized Signature _____

Agency Name _____ Street Address and City, State, Zip _____

Pay by Check:

- Check will follow for the full 2017 Associate Membership Dues amount indicated above, payable to the Home Care Association of NYS and mailed to:
HCA, 388 Broadway, 4th Floor, Albany, NY 12207
- Check enclosed.