



Provider Member Dues Application - 2018

Agency Name (Home Care Parent): _____

CEO/Authorized Representative: _____

Business Address: _____

Email/Direct Phone/Fax: _____

City/State/Zip: _____

Annual Dues

HCA Provider dues are for a calendar year, based on the agency's total patient care revenue reported from your most recently completed fiscal year (Fiscal Year 2017 Cost Report). If an agency has affiliated entities, the agency must add the revenue of ALL affiliates including but not limited to payment from MLTC, MCO, Home Care agencies, Medicare, Medicaid and private pay (but excluding inpatient institutional and adult day care) to the agency's revenue 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 provider or any entity outside the Association.** For questions about your application, please contact Laura Constable Senior Director, Membership and Operations at lconstable@hcanys.org or 518-810-0660.

Step 1 - Determine Total Revenue

Please complete the following to determine your Total Revenue from ALL patient revenue payers:

CHHA Agency Name _____
\$ _____
Patient Revenue NYS Operating Certificate # _____

LHCSA Agency Name _____
\$ _____
Patient Revenue NYS Operating Certificate # _____

MLTC/
MCO
PACE Agency Name _____
\$ _____
Patient Revenue NYS Operating Certificate # _____

Telehealth/
Case Mgmt Agency Name _____
\$ _____
Patient Revenue NYS Operating Certificate # _____

LTHHCP Agency Name _____
\$ _____
Patient Revenue NYS Operating Certificate # _____

Hospice Agency Name _____
\$ _____
Patient Revenue NYS Operating Certificate # _____

Other Agency Name _____
\$ _____
Patient Revenue NYS Operating Certificate # _____

Total Revenue: \$ _____

Step 2 - Calculate Dues

Total Patient Revenue Scale

	Dues Amount
<input type="checkbox"/> \$500 Million or greater	\$64,000
<input type="checkbox"/> \$250 Million to \$499,999,999 Million	\$59,000
<input type="checkbox"/> \$150 Million to \$249,999,999 Million	\$54,000
<input type="checkbox"/> \$100 Million to \$149,999,999 Million	\$42,000
<input type="checkbox"/> \$75 Million to \$99,999,999 Million	\$39,500
<input type="checkbox"/> \$60 Million to \$74,999,999 Million	\$37,000
<input type="checkbox"/> \$50 Million to \$59,999,999 Million	\$35,000
<input type="checkbox"/> \$40 Million to \$49,999,999 Million	\$26,500
<input type="checkbox"/> \$30 Million to \$39,999,999 Million	\$20,000
<input type="checkbox"/> \$20 Million to \$29,999,999 Million	\$19,800
<input type="checkbox"/> \$10 Million to \$19,999,999 Million	\$18,500
<input type="checkbox"/> \$5 Million to \$9,999,999 Million	\$17,000
<input type="checkbox"/> \$1 Million to \$4,999,999 Million	\$ 8,500
<input type="checkbox"/> Below one million	\$ 3,750

Total Dues \$ _____

Step 3 - Certify Information

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

Authorized Signature _____ Title (CEO, Administrator, CFO) _____ Date _____

Step 4 - Indicate Method of Payment

Charge the full amount to credit card: Visa MC AMEX Discover

Card Number _____ Expiration Date _____ Security Code _____

Billing Address _____ City _____ State _____

Printed Name _____ Authorized Signature _____

Check enclosed. Pay dues on a quarterly basis (if total dues are over \$8,500). Please note you will only receive one invoice, but will receive quarterly statements as a reminder.

Check will follow for the full amount payable to **Home Care Association of NYS.**