2019 HCA MEMBERSHIP APPLICATION

Associate Member Dues Application - 2019

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: ______________________________

For questions about your application, please contact Laura Constable, Senior Director of Member Services, at lconstable@hcanys.org or 518-810-0660.

See next page

Associate Member Dues Application - 2019

Services Provided

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

[ ] Accreditation Services
[ ] Answering Service
[ ] Billing/Information Systems
[ ] Case Management
[ ] Certified Public Accounting
[ ] Claims Management
[ ] Computer Hardware

Consulting
[ ] Education
[ ] HIPAA
[ ] Licensure/Start-up
[ ] Managed Care
[ ] Management
[ ] Nursing Practice/Clinical
[ ] OASIS
[ ] Risk Management
[ ] Training

Disease Management
[ ] CHF
[ ] COPD
[ ] Dementia/Cognitive Issues
[ ] Diabetes
[ ] End Stage Renal Disease
[ ] Maternal / Child Health
[ ] Mental Health
[ ] Wound Care
[ ] Documentation/Nursing Process
[ ] Durable / Home Medical Equipment
[ ] Employment & Benefits
[ ] Executive Search
[ ] Financial Services
[ ] Insurance
[ ] IV Therapy
[ ] Legal Services

[ ] Medical Disposal Products
[ ] Medical Product Supplier
[ ] Occupational Therapy
[ ] Outcome Measurement
[ ] Personal Emergency Response System
[ ] Pharmacy / Pharmaceutical Supplies
[ ] Physical Therapy
[ ] PRI / Screen Assessments
[ ] Publications
[ ] Quality Improvement
[ ] Respiratory Care
[ ] Scheduling
[ ] Software Supplier
[ ] Telehealth
[ ] Telephony
[ ] Other ____________________

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-lerts;
- 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 — $3,800

☐ Associate Member Organization with Annual Budget Under $250,000 — $1,650

Total: $______

Pay by Credit Card:

Charge the full 2019 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 2019 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.