Vendor Member Dues Application – 2020

HCA
HOME CARE ASSOCIATION
OF NEW YORK STATE

Agency Name: ______________________________

CEO/Authorized Rep: ______________________________

Address: ______________________________

City/State/Zip ______________________, __________ __________

Email/Direct Phone: ________________ ________________

Main Phone/Fax: ________________ ________________

Your dues at work for you!

Firms (consulting, legal, financial, etc.) should use HCA's **Association Member Application**.
Vendor Members include national providers of services related to home health care – including but not limited to durable medical equipment, supply companies, and computer software companies.

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 whom should receive billing information **- limited to one person.***
NY Sales Contact	*List the person who is the sales contact for New York from your company.*
Exhibitor Contact	*List the person(s) to whom all exhibitor/trade show information should be directed.*

Please check if applicable:
- ☐ Main *(only 1 person)*
- ☐ Directory *(only 1 person)*
- ☐ Billing *(only 1 person)*
- ☐ NY Sales
- ☐ Exhibitor
- ☐ ***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)*
- ☐ NY Sales
- ☐ Exhibitor
- ☐ ***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)*
- ☐ NY Sales
- ☐ Exhibitor
- ☐ ***Address same as above***

Name: ______________________________
Title: ______________________________
Direct Line: ________________ Fax: ________________
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Please check if applicable:
- ☐ Main *(only 1 person)*
- ☐ Directory *(only 1 person)*
- ☐ Billing *(only 1 person)*
- ☐ NY Sales
- ☐ Exhibitor
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Name: ______________________________
Title: ______________________________
Direct Line: ________________ Fax: ________________
Email: ______________________________
Mailing Address: ______________________________

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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

Vendor Member - $2,000

As a Vendor Member you will receive the following benefits:

- Discounted booth rates for HCA's signature events;
- Advance opportunity to secure HCA 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

Pay by Credit Card:

Charge the full 2020 Vendor Membership Dues of $2,000 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 2020 Vendor Membership Dues of $2,000, payable to the Home Care Association of NYS and mailed to: HCA, 388 Broadway, 4th Floor, Albany, NY 12207

☐ Check enclosed.

Please fax this completed application to 518-426-8788 or mail to HCA, 388 Broadway, 4th Floor, Albany, NY 12207