Provider Member Dues Application - 2021

HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

Agency Name (Home Care Parent): _____

CEO/Authorized Representative: _____

Business Address: _____

Email/Direct Phone/Fax: _____ _____ _____

City/State/Zip: _____, _____ _____

HCA 2021 MEMBERSHIP

Meeting the Moment and Forging Ahead With You, For You

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 2020 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 impatient 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
☐ $500 Million or greater	$70,000
☐ $250 Million to $499,999,999 Million	$64,000
☐ $150 Million to $249,999.999 Million	$58,500
☐ $100 Million to $149,999,999 Million	$46,250
☐ $75 Million to $99,999,999 Million	$43,250
☐ $60 Million to $74,999,999 Million	$40,000
☐ $50 Million to $59,999,999 Million	$38,000
☐ $40 Million to $49,999,999 Million	$30,000
☐ $30 Million to $39,999,999 Million	$22,000
☐ $20 Million to $29,999,999 Million	$21,000
☐ $10 Million to $19,999,999 Million	$20,000
☐ $5 Million to $9,999,999 Million	$18,500
☐ $1 Million to $4,999,999 Million	$ 9,250
☐ Below one million	$ 4,100

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 ☐ AMExp ☐ Discover

_____ _____ _____
Card Number Expiration Date Security Code

_____ _____ _____
Billing Address City State

_____ _____
Printed Name Authorized Signature

☐ Check enclosed.

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

☐ Pay dues on a quarterly basis (if total dues are over $9,000). Please note you will only receive one invoice, but will receive quarterly statements as a reminder.

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