

Vendor Member Dues Application – 2021



Agency Name: _____
CEO/Authorized Rep: _____
Address: _____
City/State/Zip: _____
Email/Direct Phone: _____
Main Phone/Fax: _____

*Meeting the
Moment and
Forging Ahead
With You,
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: _____
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: _____



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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.

- | | | |
|--|---|---|
| <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 |
| | <input type="checkbox"/> Wound Care | <input type="checkbox"/> Publications |
| | <input type="checkbox"/> Documentation/Nursing Process | <input type="checkbox"/> Quality Improvement |
| <u>Consulting</u> | <input type="checkbox"/> Durable / Home Medical Equipment | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Education | <input type="checkbox"/> Employment & Benefits | <input type="checkbox"/> Scheduling |
| <input type="checkbox"/> HIPAA | <input type="checkbox"/> Executive Search | <input type="checkbox"/> Software Supplier |
| <input type="checkbox"/> Licensure/Start-up | <input type="checkbox"/> Financial Services | <input type="checkbox"/> Telehealth |
| <input type="checkbox"/> Managed Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Telephony |
| <input type="checkbox"/> Management | <input type="checkbox"/> IV Therapy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nursing Practice/Clinical | <input type="checkbox"/> Legal Services | |
| <input type="checkbox"/> OASIS | | |
| <input type="checkbox"/> Risk Management | | |
| <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

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-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

Pay by Credit Card:

Charge the full 2021 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.