2023 MLTC Provider Member Dues Application

HCA HOME CARE ASSOCIATION OF NEW YORK STATE

Agency Name: _____

CEO/Authorized Rep: _____

Address: _____

City/State/Zip _____, _____ _____

Email/Direct Phone: _____ _____

Main Phone/Fax: _____ _____

Step 1 – Determine Total Revenue

Please show the following to determine your Total Revenue:

☐ MLTC _____
Agency Name

$_____ _____
Patient Revenue NYS Operating Certificate #

☐ MLTC _____
Agency Name

$_____ _____
Patient Revenue NYS Operating Certificate #

☐ MLTC _____
Agency Name

$_____ _____
Patient Revenue NYS Operating Certificate #

Total Revenue: $_____

Annual Dues

Managed Long Term Care (MLTC) programs that are part of a system that provide other types of home care (such as a CHHA, LTHHCP or LHCSA) should use **HCA's Provider Membership Dues Application.** HCA dues are for a calendar year based on the agency's total home care patient revenue in New York reported from your most recently completed fiscal year. Freestanding MLTCs, or those MLTCs that are part of a system that are not providing any other type of home care services must report total home care patient revenue.

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

Step 2 – Calculate Dues

$400 million or greater	$50,000
$200 million to $399.9 million	$37,000
$100 million to $199.9 million	$24,000
$50 million to $99.9 million	$19,000
$25 million to $49.9 million	$13,250
Below $25 million	$10,250

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 ☐ MasterCard ☐ AMExp ☐ Discover ☐

_____ _____ _____
Card Number Expiration Date Security Code

_____ _____
Printed Name Authorized Signature

_____
Mailing Address (Including Street, City, State and Zip)

Or choose another payment method:

☐ Check will follow for the full amount payable to: Home Care Association of NYS, 388 Broadway, 4th Floor, Albany, NY 12207

☐ Pay dues on a quarterly basis. 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