

**HOME CARE ASSOCIATION OF COLORADO
PROVIDER MEMBER APPLICATION FOR YEAR 2012**

7400 East Arapahoe Road, #211, Centennial, Colorado 80112

◆ PHONE (303) 694-4728 ◆ FAX (303) 694-4869

◆ E-mail: hcac@assnoffice.com ◆ Website: www.hcaonline.org

Membership Category: HOME CARE PROVIDER

A company that provides health-related services and products in the place of residence to persons who have health-related needs, thereby affording a continuum of comprehensive client care. Membership dues apply through December 2012.

(Please complete the following information)

Agency Name: _____

Key Contact: _____ **Title:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

Website Address: _____ **Medicare Provider #** _____

State License Number: _____ **Class of License** _____

Additional Colorado Locations:

1. Agency Name: _____

Key Contact Person: _____ **Title:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

E-mail address: _____ **Website address:** _____

Medicare Provider #: _____ **License #** _____ **Class of License** _____

2. Agency Name: _____

Key Contact Person: _____ **Title:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

E-mail address: _____ **Website address:** _____

Medicare Provider #: _____ **License #** _____ **Class of License** _____

Additional Locations Continued:

3. Agency Name: _____
Key Contact Person: _____ Title: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-mail address: _____ Website address: _____
Medicare Provider #: _____ License # _____ Class of License _____

4. Agency Name: _____
Key Contact Person: _____ Title: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-mail address: _____ Website address: _____
Medicare Provider #: _____ License # _____ Class of License _____

5. Agency Name: _____
Key Contact Person: _____ Title: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-mail address: _____ Website address: _____
Medicare Provider #: _____ License # _____ Class of License _____

6. Agency Name: _____
Key Contact Person: _____ Title: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-mail address: _____ Website address: _____
Medicare Provider #: _____ License # _____ Class of License _____

7. Agency Name: _____
Key Contact Person: _____ Title: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
E-mail address: _____ Website address: _____
Medicare Provider #: _____ License # _____ Class of License _____

Agency Demographics

Is your agency: Hospital Based Free Standing For Profit Not For Profit
Large (3 or more Colorado locations) Small (1 or 2 Colorado Locations)
Governmental

Total # of employees: _____ Average Daily Census: _____

Total Miles Driven (Most Recent FY): _____ Total # Visits (Most Recent FY): _____

Who is your agency's Medicare Administrative Contractor? _____

Please tell us your agency's fiscal year end: _____

Yes, I provide services to clients in another state. Please list state(s): _____

Do you belong to: NAHC (National Association for Home Care)
COCHPC (Colorado Center for Hospice & Palliative Care)
NPDA (National Private Duty Association)
Other associations (please list): _____

What counties in Colorado do you serve? _____

What cities in Colorado do you serve? _____

CERTIFICATION / ACCREDITATION

Medicare Home Health Medicare Hospice JCAHO CHAP ACHC

HOME HEALTH

Medical Social Worker Physical Therapy Occupational Therapy
Speech Therapy Skilled Nursing Home Health Aide

PRIVATE-DUTY **More than 60% of my agency's business is private pay? YES NO**

CNA/HHA LPN RN Companion Live-In Other _____

HOSPICE

Bereavement Program Home Health Aide Medical Social Worker
Occupational Therapy Pastoral Care Physical Therapy
Respite Care Skilled Nursing Speech Therapy
Volunteers IV Therapy Providers HME / Respite Provider
Infusion Prescription Other _____

INFUSION SERVICES Infusion Prescription Other _____

CALCULATE DUES AS FOLLOWS:

Each home care provider joining HCAC has just one membership in HCAC. *This membership will include all locations that the company operates in Colorado.* Each location that the company operates will receive membership benefits such as electronic communications; a free listing and access to the member-only section of HCAC’s web site; discounted continuing education, convention and other event registrations; eligibility to serve on councils, task forces and board of directors; and eligibility to attend regional forum meetings.

Dues that the home care provider pays are based on *actual gross client care revenue for all locations received at all Colorado locations from all sources for all services and products (skilled home health; skilled long hour; unskilled home care; hospice; HME; infusion; oxygen; other) provided in the place of residence to persons who have health-related needs during the company’s most recent fiscal year.* This includes both hourly and per visit billings, and includes but is not limited to Medicaid, Medicare, private pay, commercial insurance, managed care contracts, and patient co-payment. It does not include in-kind amounts recorded.

PLEASE ENTER REVENUE & TOTAL DUES FROM THE ATTACHED HCAC DUES WORKSHEET:

Gross Client Revenue for Most Recent Fiscal Year \$ _____

Total Dues for 2012: \$ _____*

*Minimum Dues for first-time members \$850 to include membership application fee; Maximum Dues are \$7,620.

Authorized Signature: _____

By signing above and/or remitting dues to HCAC, I agree that HCAC has explicit permission to contact representatives of this company in person, or by mail, phone, facsimile, e-mail or any other commonly accepted form of communication.

Dues will be paid: (please check one)

Annually

Semi-Annually*

Quarterly*

Check enclosed or

Credit Card

VISA

MC

AMEX

DISCOVER

Cardholder’s name (print) _____

Card Number _____/_____/_____/_____ Exp. Date: _____

Signature _____

* Each Quarterly or Semi-Annual bill generated by the HCAC office will include a \$10 handling/processing fee. Quarterly or Semi-Annual payments are not allowed if your account was delinquent more than 60 days in the previous year.

Payments to the Home Care Association of Colorado are not deductible as charitable contributions for federal income tax purposes. HCAC dues are an allowable cost in the Medicare Cost Report (see PRM-15 Section 2138). The 1994 Federal Revenue Reconciliation Act requires that for all payments issued in **2011** you may only deduct **68%** as an ordinary and necessary business expense for federal income tax purposes. Tax ID # 84-6085778.

Return this form to:

Home Care Association of Colorado, 7400 East Arapahoe Road, #211, Centennial, Colorado 80112

HCAC OFFICE USE ONLY:					
Date Received	Dues Amt \$	Paid \$	Ck/Auth#	Q	
INV 1/1	/ \$	Received \$	Ck/Auth#	Q	
INV 4/1	/ \$	Received \$	Ck/Auth#	Q	
INV 7/1	/ \$	Received \$	Ck/Auth#	Q	
INV 10/1	/ \$	Received \$	Ck/Auth#	Q	
New List	Welcome letter	dBase	Web listing	Completed by	

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