Home Care & Hospice Association of NJ

2017 PROVIDER MEMBERSHIP APPLICATION

PRIMARY CONTACT

*****Election Ballot will be mailed to this contact*

****Information will be used for 2017 Membership Directory*

Organization _____

Contact Person _____

Title _____

Address _____

Suite _____ City _____

State _____ Zip Code _____

Email _____

Phone _____

Fax _____

Website _____

Facebook address_____

Twitter Handle_____

Accounts Payable

Invoices will be mailed to this contact

Contact _____

Title _____

Email _____

Phone _____

Administration (CEO or Executive Director)

Contact _____

Title _____

Email _____

Phone _____

Finance (CFO)

Contact _____

Title _____

Email _____

Phone _____

Clinical Director/DON

Contact _____

Title _____

Email _____

Phone _____

Billing Supervisor

Contact _____

Title _____

Email _____

Phone _____

Compliance Officer

Contact _____

Title _____

Email _____

Phone _____

Quality Director

Contact _____

Title _____

Email _____

Phone _____

CHHA Nursing Supervisor

Contact _____

Title _____

Email _____

Phone _____

Marketing Director

Contact _____

Title _____

Email _____

Phone _____

Social Media

Contact _____

Title _____

Email _____

Phone _____

Rehab Director

Contact _____

Title _____

Email _____

Phone _____

Government Affairs Director / Public Policy
Contact _____
Title _____
Email _____
Phone _____

CHHA Coordinator
Contact _____
Title _____
Email _____
Phone _____

Professional Education Contact
Contact _____
Title _____
Email _____
Phone _____

Referral Intake Department Director
Contact _____
Title _____
Email _____
Phone _____

Emergency Preparedness Representative
Contact _____
Title _____
Email _____
Phone _____

Home Health Social Work
Contact _____
Title _____
Email _____
Phone _____

HOME CARE VENDOR

DME
Contact _____
Title _____
Email _____
Phone _____

Medical Supplies Vendor
Contact _____
Title _____
Email _____
Phone _____

HOSPICE PERSONNEL

Hospice Director
Contact _____
Title _____
Email _____
Phone _____

Hospice Clinical Director
Contact _____
Title _____
Email _____
Phone _____

QAPI
Contact _____
Title _____
Email _____
Phone _____

Professional Education Contact
Contact _____
Title _____
Email _____
Phone _____

Social Work
Contact _____
Title _____
Email _____
Phone _____

Bereavement Coordinator

Contact _____
Title _____
Email _____
Phone _____

Volunteer Coordinator

Contact _____
Title _____
Email _____
Phone _____

Chaplain

Contact _____
Title _____
Email _____
Phone _____

Billing Supervisor

Contact _____
Title _____
Email _____
Phone _____

Ethics

Contact _____
Title _____
Email _____
Phone _____

Palliative Care Director

Contact _____
Title _____
Email _____
Phone _____

HOSPICE VENDOR

Pharmacy

Contact _____
Title _____
Email _____
Phone _____

DME

Contact _____
Title _____
Email _____
Phone _____

Medical Supplies Vendor

Contact _____
Title _____
Email _____
Phone _____

Additional Staff for Email Network:

Name_____
Title _____
Email _____

Name_____
Title _____
Email _____

Name_____
Title _____
Email _____

ADDITIONAL HOSPICE QUESTIONS

Hospice Average Length of Stay in days? _____

Hospice Median Length of Stay in days? _____

Do you have a palliative care program? _____

Do you have a pediatric palliative care program? ___

Home Care & Hospice Association of NJ

2017 PROVIDER MEMBERSHIP APPLICATION

LICENSURE

Please submit a copy of your license with this application.
License number(s) are required for membership. Indicate licenses by specific location on the following page.

Licenses Included in this Membership:

☐ Health Care Service Firm
☐ Home Health Agency
☐ Hospice
Do you operate a Hospice Residential Facility?
Where? _____

OWNERSHIP (Type of Organization)

☐ For Profit ☐ Non-Profit

Classification: ☐ LLC
☐ Corporation ☐ Individual/Sole Proprietor
☐ Hospital Based ☐ Health System
☐ Part of ACO? If so, which one? _____
☐ Other: _____

Name of Owner: _____

ACCREDITATION

Check all accreditations applicable to this membership

☐ ACHC ☐ CAHC ☐ CHAP
☐ NAHC ☐ TJC ☐ NIHCA
☐ Other_____

AGENCY DATA

Total Number of NJ Offices _____
Total Employees (Admin & Field) _____
Patient Census 2016 (duplicated) _____

Counties Served: ☐ All Counties in New Jersey

☐ Atlantic ☐ Bergen ☐ Burlington
☐ Camden ☐ Cape May ☐ Cumberland
☐ Essex ☐ Gloucester ☐ Hudson
☐ Hunterdon ☐ Mercer ☐ Middlesex
☐ Monmouth ☐ Morris ☐ Ocean
☐ Passaic ☐ Salem ☐ Somerset
☐ Sussex ☐ Union ☐ Warren

MEMBER OF:

☐ National Association for Home Care (NAHC)
☐ National Hospice & Palliative Care Org (NHPCO)
☐ Home Care Associations of America (HCAOA)
☐ Home Health Services & Staffing (HHSSA-NJ)
☐ Visiting Nurse Associations of America (VNAA)
☐ LeadingAge NJ
☐ Health Care Association of NJ
☐ NJ Hospital Association
☐ Home Care Council of NJ
☐ Partnership for Quality Home Healthcare
☐ Alliance for Home Health Quality & Innovation
☐ Other: _____

INSURANCE ACCEPTED/PAYER

☐ Commercial Insurance
- ☐ Aetna
- ☐ Amerihealth
- ☐ Blue Cross Blue Shield
- ☐ Cigna
- ☐ United Health Care
- ☐ Other: _____

☐ Medicaid FFS
☐ Medicaid Managed Care
- ☐ Aetna
- ☐ Amerigroup
- ☐ Horizon NJ Health
- ☐ United Health Care
- ☐ WellCare

☐ Managed Care Services Provided
- ☐ PCA ☐ MLTSS ☐ DDD ☐ PDN ☐ PEDS

☐ Medicare
☐ Long-Term Care Insurance
☐ Private Pay
☐ Worker's Comp
☐ VA
☐ Other: _____

EMR System Used: _____

Home Care & Hospice Association of NJ

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Click here to add an additional Location page, Please note that any data entered on this page will be duplicated on the new page and placed at the end of this section. You may wish to enter data that will be repeated for the different locations before clicking here.

LOCATIONS & LICENSURE

Please submit a copy of your license(s) with this application. License number(s) are required for membership. All New Jersey Health Care Service Firm, Home Health Agency and/or Hospice licenses must be included on this application. Photocopy this page as needed.

▶AGENCY NAME:

_____

License Type: ☐ Health Care Service Firm
☐ Home Health Agency ☐ Hospice

License # _____

Medicare Provider # _____

☐ Check here if contact information below is the same as listed under *Primary Contact* on page 1.

Main Contact _____
Title _____
Address _____
Suite _____ City _____
State _____ Zip Code _____
Email _____
Phone _____
Fax _____

Services Offered: *check all that apply*

☐ Behavioral Health	☐ Bereavement / Grief Counseling	☐ Case Management
☐ CHHA Hourly	☐ CHHA Live-in	☐ Chronic Care Mgt
☐ Companion	☐ Dementia Care	☐ Emergency Response Systems
☐ Geriatric Care Management	☐ Home Infusion/Intravenous Therapy	☐ Home Medical Equipment
☐ Maternal Health	☐ Medical Social Worker	☐ Medication Management
☐Pediatric Hospice	☐ Mobile Meals	☐ Nursing
☐ Occupational Therapy	☐ Palliative Care	☐ Pediatric Care
☐ Pediatric Shift Nursing	☐ Physical Therapy	☐ Private Duty Nursing
☐ Psychiatric Nursing	☐ Registered Dietitian	☐ Respite Care
☐ Speech Therapy	☐ Staffing (CNA, CHHA	☐ Telehealth Monitoring
☐ Transportation	☐ Ventilator Care	

Counties Served: ☐ All Counties in New Jersey

☐ Atlantic	☐ Bergen	☐ Burlington
☐ Camden	☐ Cape May	☐ Cumberland
☐ Essex	☐ Gloucester	☐ Hudson
☐ Hunterdon	☐ Mercer	☐ Middlesex
☐ Monmouth	☐ Morris	☐ Ocean
☐ Passaic	☐ Salem	☐ Somerset
☐ Sussex	☐ Union	☐ Warren

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ANNUAL DUES: *The Association will not disclose this information for any purpose, to any party outside the Association, other than the Association's attorneys, accountants, auditors or other advisors.*

Step 1: DETERMINE YOUR REVENUE

Please list your Patient Service **gross** Revenue beside each license type. Patient Service Revenue is the total charges, less contractual allowances, if any, for **all** patient revenue for **all** licensed offices included on this application based on the prior year. For first time members, inclusion of the agencies audited, consolidated financial statement may be requested.

☐ Health Care Service Revenue $_____

☐ Home Health Agency Revenue $_____

☐ Hospice Revenue $_____

TOTAL PATIENT SERVICE REVENUE= $0.00

Step 2: DUES CALCULATION

Check beside the dues level based on your total patient service revenue from step 1 and write below

Total Patient Revenue Scale	Dues Amount
☐ Less than $250,000	$1,135.80
☐ $250,001 to $500,000	$1,460.31
☐ $500,001 to $1 Million	$2,271.59
☐ $1,000,001 to $1.5 Million	$3,245.13
☐ $1,500,001 to $2 Million	$4,543.18
☐ $2,000,001 to $3 Million	$7,031.12
☐ $3,000,001 to $5 Million	$9,735.39
☐ $5,000,001 to $7.5 Million	$11,357.96
☐ $7,500,001 to $10 Million	$12,331.49
☐ $10,000,001 to $15 Million	$13,413.20
☐ $15,000,001 to $20 Million	$14,494.91
☐ $20,000,001 to $25 Million	$15,414.37
☐ $25,000,001 to $30 Million	$16,496.08
☐ $30,000,001 to $35 Million	$17,577.79
☐ $35,000,001 to $40 Million	$18,389.07
☐ $40,000,001 to $60 Million	$19,578.95
☐ $60,000,001 to $80 Million	$25,250.00
☐ $Over 80 Million	$28,000.00

TOTAL ANNUAL DUES AMOUNT = $0.00

Step 3: CERTIFY INFORMATION

I certify that the declared revenue information provided on this application is true and correct.

_____

Print Name Title *(CEO/Administrator/CFO only)*

_____

Authorized Signature Required Date

Step 4: PAYMENT SCHEDULE

☐ Full Annual Payment: Due January 1st

☐ Tri-annual Payments: Due Jan. 1st, Apr. 1st, July 1st

☐ Tri-annual Automatic Payments by Credit Card: Due Jan. 1st, Apr. 1st, July 1st

Submit credit card information below

Step 5: DUES PAYMENT

►**Check Payment**: ☐ Check # _____

Payment Amount $ 0.00

►**Credit Card Payment:**

☐ One-time Payment ☐ Enroll 2 Auto Payments (Jan,Jun)

☐ Enroll Tri-Annual Auto-Payments (Jan, Apr, Jul)

There will be a 2.5% fee if paying by credit card:

$0.00 *x 1.025* = $0.00

Payment Amount Total Due

Card: ☐ Visa ☐ MasterCard ☐ American Express

_____

Credit Card Number

_____

Exp Date CVV

_____

Address of Cardholder

_____

_____

Authorized Signature Required Date

MEMBERSHIP AGREEMENT

Contributions or gifts to the Home Care & Hospice Association of NJ are not deductible as charitable contributions for Federal Income Tax purposes. However, dues payments are deductible by members as an ordinary and necessary business expense except for the percentage of dues used for lobbying by the Home Care & Hospice Association of NJ. The non-deductible percentage of dues is estimated to be approximately 20%.

In accordance with the FCC Regulations, I give the Home Care & Hospice Association of NJ permission to fax and/or email me or my organization/company, in order to provide me with the information on future Home Care & Hospice Association of NJ events, services or other activities.

I understand that our agency is expected to honor this membership commitment through the end of the dues/calendar year. Thus, notwithstanding the selection of a tri-annual or automatic payment plan, membership dues are deemed due and owing in full on January 1st of the applicable year for existing members renewing membership and the date membership is effective for new members. Thus, if a member terminates membership at any time during the applicable year, any and all outstanding unpaid dues for the year shall be due in full upon resignation or termination of membership. No refund of any portion of membership dues for an applicable year shall be made to any member upon resignation or termination of membership.

I hereby certify, to the best of my knowledge and belief, that the information contained in this Membership Application, including but not limited to financial information declared in support of the determination of membership dues, is true and accurate. I agree to be bound by the terms and conditions of membership, including but not limited to the terms of the payment agreement.

SIGNATURE REQUIRED:

Authorized Signature _____ Date _____

Print Name _____ Title _____

Organization _____

FOR INTERNAL USE:

Membership Status: ☐ Renewal Application ☐ New Member Application: *Effective Date* _____

STATEMENT OF ETHICAL VALUES

The Home Care & Hospice Association of New Jersey represents home health agencies, hospices, and health care service firms. The Association promotes accessible, high quality skilled and supportive services that are delivered to people in their places of residence throughout New Jersey. The mission of the Association is to serve as the catalyst for excellence in home care and hospice.

The Home Care & Hospice Association of NJ seeks to promote an ethical corporate culture amongst its members so that internal and external relationships are grounded in the fundamental ethical values of autonomy, beneficence, non-malfeasance and justice.

Our members' policies should reflect these significant ethical values:

- Respect
- Dignity
- Quality
- Impartiality
- Honesty
- Integrity
- Trust
- Accountability
- Responsibility
- Reliability
- Confidentiality
- Teamwork
- Professionalism
- Loyalty

The Home Care & Hospice Association of NJ recognizes that situations do and will arise when ethical values conflict. The Home Care & Hospice Association of NJ expects that each member organization has a process in place to deal with situations arising from such conflicts.

It should be further noted that the bylaws of the Home Care & Hospice Association of NJ require:

For those cases where a member has been found guilty of fraudulent or abusive practice in an administrative agency or court of law, and/or whose license has been revoked or suspended for more than 30 days for fraud and abuse, and has not been approved for reinstatement to provide home care, hospice, or other services, membership status will be immediately terminated upon the receipt of formal documentation. The organization will be obligated to pay any outstanding dues in accordance with the Association's Membership Dues Policy.

SIGNATURE REQUIRED:

I have received and read the above Statement of Ethical Values

Authorized Signature _____ Date _____

Print Name _____ Title _____

Organization _____

NJ Home Care & Hospice Political Action Committee (PAC) Contribution

The Home Care & Hospice Association of NJ Board of Directors voted to create a political action committee, the NJ Home Care & Hospice PAC (NJHCH PAC) to offer members concerned with challenges confronting the home care community the means to support worthy candidates for state elected office. The purpose of NJHCH PAC is to support the full scope of home care providers, including home health agencies, hospices and health care service firms throughout New Jersey.

NJHCH PAC will support by lawful means candidates in New Jersey, regardless of their political affiliations, who are dedicated to good government and have an appreciation of the importance of health, home care and hospice providers and the services they offer.

Your participation in the NJHCH PAC produces greater political power. Protecting home care and hospice providers and the patients and families we serve cannot be done without commitment.

Your support is needed to elevate the voice of the home care and hospice community in NJ.

FOR PROFIT COMPANIES ARE ENCOURAGED TO CONTRIBUTE TO THE PAC AND MAY CONTRIBUTE UP TO $7,200.00 PER CALENDAR YEAR UNDER NEW JERSEY CAMPAIGN FINANCE LAW. NON-PROFIT COMPANIES CAN NOT MAKE COMPANY CONTRIBUTIONS, BUT INDIVIDUALS ARE ENCOURAGED TO SUPPORT THE PAC WITH VOLUNTARY CONTRIBUTIONS MADE WITH PERSONAL FUNDS. CONTRIBUTIONS TO THE PAC MAY NOT BE REIMBURSED AND ARE NOT DEDUCTIBLE AS A BUSINESS EXPENSE OR FOR FEDERAL INCOME TAX PURPOSES. Partnerships, LLPs, and LLCs may not contribute as entities, but a contribution may be drawn on the account of a partnership, LLP, or LLC and is treated as a personal contribution by the partner or member who signs the check or written interest.

Check Payment: ☐ Check # _____ Payment Amount $ _____

Checks should be made payable to: **NJ Home Care & Hospice PAC**

Credit Card Payment Options:

Total Contribution Amount $ _____

☐ One-time Payment OR

☐ Enroll in 2 Auto-Payments (Jan & Jun)

Card: ☐ Visa ☐ MasterCard ☐ American Express

Name as it Appears on Credit Card: _____

Company Name as it Appears on Credit Card: _____

Credit Card Number: _____

Exp. Date: _____ CVV #: _____

Billing Address of Cardholder: _____

Printed Name: _____

Authorized Signature: _____

DID YOU REMEMBER: For Provider Members

- ✓ Complete all sections of agency information.
- ✓ Complete Location and Licensure section for **every** location included in your membership on page 5
- ✓ Complete steps 1 through 5 of Annual Dues section on page 6
- ✓ Sign and date the membership agreement on page 7
- ✓ Sign and date the Statement of Ethical Values Form on page 8
- ✓ Attach a copy of each NJ Licensed Health Care Service Firm, Home Health Agency, and/or Hospice license
- ✓ Your consideration of a New Jersey Home Care & Hospice PAC contribution would be greatly appreciated. This form can be found on Page 9.

Return Application in full to:

Susan Manders
Home Care & Hospice Association of NJ
485D Route 1 South
Suite 210
Iselin, NJ 08830

Or
Email to
susan@homecarenj.org

Or
Fax to
(732) 877-1101