



2012 Provider Membership Application

Eligible providers are organizations licensed in NJ as a home health agency, health care service firm, and/or hospice

PRIMARY CONTACT - Election Ballot will be mailed to this contact

Agency Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Website: \_\_\_\_\_

SENIOR MANAGEMENT

ADMINISTRATION (CEO or Executive Director)

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

FINANCE (CFO)

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

CLINICAL DIRECTOR

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

LICENSURE- Please submit a copy of your license(s) with this application

License number(s) required for membership. Please list only those licenses that are included in your dues calculation. Use separate sheet if necessary.

Health Care Service Firm Name: \_\_\_\_\_

License #(s): \_\_\_\_\_

Home Health Agency Name: \_\_\_\_\_

License #(s): \_\_\_\_\_

Medicare Provider #(s): \_\_\_\_\_

Hospice Agency Name: \_\_\_\_\_

License #(s): \_\_\_\_\_

Medicare Provider #(s): \_\_\_\_\_

**OWNERSHIP**

**Classification:**  Individual/Sole Proprietor  Corporation  Other: \_\_\_\_\_

**Name of Owner:** \_\_\_\_\_

**ACCREDITATION- *Check all that apply***

ACHC  CAHC  CHAP  NAHC  TJC  Other: \_\_\_\_\_

**AGENCY DATA**

**Enter total number of:** NJ Offices: \_\_\_\_\_ Total Employees (Admin & Field): \_\_\_\_\_

Nurses \_\_\_\_\_ PTs \_\_\_\_\_ STs \_\_\_\_\_ OTs \_\_\_\_\_ SWs \_\_\_\_\_ CHHAs \_\_\_\_\_

**Patient Census 2011** \_\_\_\_\_

**Counties Served:** \_\_\_\_\_

**Services Offered:**

Skilled Nursing Visits  CHHA (hourly)  ST  Medical Social Worker  
 Private Duty Nursing  PT  OT  Companion  Live-In

**ADDITIONAL STAFF- *Information will be used for targeted email notifications***

CHHA Manager/Supervisor: \_\_\_\_\_ Email: \_\_\_\_\_

CIO/IT/IS Director: \_\_\_\_\_ Email: \_\_\_\_\_

COO/ Director of Operations: \_\_\_\_\_ Email: \_\_\_\_\_

Communications Director: \_\_\_\_\_ Email: \_\_\_\_\_

Compliance Officer: \_\_\_\_\_ Email: \_\_\_\_\_

Education Director: \_\_\_\_\_ Email: \_\_\_\_\_

Hospice Director: \_\_\_\_\_ Email: \_\_\_\_\_

Human Resources Director: \_\_\_\_\_ Email: \_\_\_\_\_

Rehab Manager: \_\_\_\_\_ Email: \_\_\_\_\_

**ANNUAL MEMBERSHIP DUES CALCULATION** (Please check revenue level below)

Revenue Level**	Prior Year Patient Service Revenue*	2012 Provider Agency Dues Amount
	0 to 250,000	\$ 1,050
	250,001 to 500,000	\$ 1,350
	500,001 to 1 million	\$ 2,100
	1,000,001 to 2 million	\$ 4,200
	2,000,001 to 3 million	\$ 6,500
	3,000,001 to 5 million	\$ 9,000
	5,000,001 to 7.5 million	\$ 10,500
	7,500,001 to 10 million	\$ 11,400
	10,000,001 to 15 million	\$ 12,400
	15,000,001 to 20 million	\$ 13,400
	20,000,001 to 25 million	\$ 14,250
	25,000,001 to 30 million	\$ 15,250
	30,000,001 to 35 million	\$ 16,250
	35,000,001 to 40 million	\$ 17,000
	Over 40 million	\$ 18,100

**We agree to pay our dues by the following payment schedule:**

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Annual</b><br>1 payment due January 10, 2012   | <input type="checkbox"/> <b>Quarterly</b><br>1 <sup>st</sup> payment due January 10, 2012<br>2 <sup>nd</sup> payment due April 10, 2012<br>3 <sup>rd</sup> payment due July 10, 2012<br>4 <sup>th</sup> payment due October 10, 2012 |
| <input type="checkbox"/> <b>Semi-Annual</b><br>1 <sup>st</sup> payment due January 10, 2012<br>2 <sup>nd</sup> payment due July 10, 2012 |  |

\***Patient Service Revenue** is the total charges less contractual allowances, if any, for all patient revenue for all licensed offices included in your dues calculation (home health agency, hospice, and/or health care service firm)

**\*\*All applicants must submit proof of revenue level unless your organization declares the highest level of Over 40 Million.** Acceptable proof of revenue level may include the most recent copy of one of the following: copy of most recent tax return(s), audited financial statement(s) or cost report(s). You must also certify that the information provided is true and accurate. Providers in operation for less than one (1) year must submit other available financial proof acceptable to the Home Care Association of NJ, and must certify that the information provided is true and accurate.

**PAYMENT AGREEMENT- *Application must be signed and dated***

Contributions or gifts to the Home Care 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 Association of NJ. The non-deductible percentage of dues is estimated to be approximately 13%.

In accordance with the FCC Regulations, I give the Home Care 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 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 a semi-annual or quarterly payment plan, membership dues are deemed due and owing in full on January 1 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 submitted 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 this payment agreement.

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**Authorized Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Payment:**

**Total Amount Due:** \_\_\_\_\_ **Amount of first payment:** \_\_\_\_\_

**Check Number:** \_\_\_\_\_

**Credit Card:**     Visa                       MasterCard                       American Express

**Credit Card Number:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **CVV#** \_\_\_\_\_

**Address on card:** \_\_\_\_\_

**Name on Card:** \_\_\_\_\_ **Signature of Cardholder:** \_\_\_\_\_

***Please return application, payment information, Statement of Ethical Values, proof of previous year's revenue and copy of license(s) to:***

*Donna Weiss, Director of Operations and Finance, Home Care Association of NJ at  
485D Route 1 South, Suite 210, Iselin, NJ 08830 or fax to (732) 877-1101*



# Statement of Ethical Values

The Home Care 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 NJ. The mission of the Association is to serve as the catalyst for excellence in home care & hospice.

The Home Care 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-maleficence 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 Association of NJ recognizes that situations do and will arise when ethical values conflict. The Home Care 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 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 & 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.

**I have received and read the above Statement of Ethical Values:**

Authorized Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Organization: \_\_\_\_\_

***This page must be signed and returned with membership application***

### Did You Remember To?

#### **ALL MEMBERS:**

- Sign and Date the Application.
- Sign and Date the *Statement of Ethical Values page*.
- Enclose payment.

#### **ADDITIONAL REQUIREMENTS FOR PROVIDER MEMBERS:**

- Attach copies of all licenses listed on page 1 of the application.
- Select dues level on page 3 of the application (be sure to include revenue for all licenses listed on page 1).
- Attach proof of revenue level per instructions on page 3 of the application.
- Select payment schedule.

If you have any questions regarding the membership application or any of the required documents please contact Donna Weiss, Director of Operations & Finance at [donna@homecarenj.org](mailto:donna@homecarenj.org) or (732) 877-1100.

**All information must be completed and submitted  
to process membership application**