

**Home Care Association of New Jersey**  
**2010 Membership Application**  
**PROVIDER MEMBERSHIP**



*Provider = Organizations licensed as a home health agency, health care service firm, and/or hospice.*

**PLEASE PRINT OR TYPE**

**PRIMARY CONTACT – Election Ballot will be mailed to this contact.**

Agency Name \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Title \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ Web Address \_\_\_\_\_

**SENIOR MANAGEMENT**

**ADMINISTRATION**

Contact Person \_\_\_\_\_ Title \_\_\_\_\_  
Email \_\_\_\_\_ Phone \_\_\_\_\_

**FINANCE**

Contact Person \_\_\_\_\_ Title \_\_\_\_\_  
Email \_\_\_\_\_ Phone \_\_\_\_\_

**CLINICAL**

Contact Person \_\_\_\_\_ Title \_\_\_\_\_  
Email \_\_\_\_\_ Phone \_\_\_\_\_

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

**LICENSE NUMBER(S) REQUIRED FOR MEMBERSHIP – Please include only the licenses that are included in your dues calculation. Use separate sheet if necessary.**

**Home Health Agency Name** \_\_\_\_\_  
License Number(s) \_\_\_\_\_  
Medicare Provider Number(s) \_\_\_\_\_

**Hospice Agency Name** \_\_\_\_\_  
License Number(s) \_\_\_\_\_  
Medicare Provider Number(s) \_\_\_\_\_

**Health Care Service Firm Name** \_\_\_\_\_  
License Number(s) \_\_\_\_\_

## ACCREDITATION

**TYPE(S) OF ACCREDITATION:** (check all that apply)

- CHAP                       Joint Commission                       CAHC  
 NAHC                       ACHC                       OTHER \_\_\_\_\_

## AGENCY DATA

**Total Number of:** Nurses \_\_\_\_\_ PT \_\_\_\_\_ OT \_\_\_\_\_ ST \_\_\_\_\_ SW \_\_\_\_\_ CHHAs \_\_\_\_\_ **Number of Offices:** \_\_\_\_\_  
**Total Number of Employees (Admin & Field):** \_\_\_\_\_ **Patient Census 2009** \_\_\_\_\_  
**Counties Served** \_\_\_\_\_

**Services Offered:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Skilled Nursing  | <input type="checkbox"/> Medical Social Worker | <input type="checkbox"/> Primary Care              |
| <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Companion             | <input type="checkbox"/> Geriatric Care Management |
| <input type="checkbox"/> PT               | <input type="checkbox"/> Private Duty Nursing  | <input type="checkbox"/> DME                       |
| <input type="checkbox"/> OT               | <input type="checkbox"/> Adult Day Care        | <input type="checkbox"/> Telehealth                |
| <input type="checkbox"/> ST               | <input type="checkbox"/> Respite               |  |

**Are you unionized:**  Yes                       No                      If yes, name of union(s) \_\_\_\_\_

## ANNUAL DUES CALCULATION

**We agree to pay our dues by the following option**

- ( ) **Annual (One Payment)**  
1<sup>st</sup> payment due **January 10, 2010**
- ( ) **Quarterly**  
1<sup>st</sup> payment due **January 10, 2010**  
2<sup>nd</sup> payment due **April 10, 2010**  
3<sup>rd</sup> payment due **July 10, 2010**  
4<sup>th</sup> payment due **October 10, 2010**
- ( ) **Semi-Annual**  
1<sup>st</sup> payment due **January 10, 2010**  
2<sup>nd</sup> payment due **July 10, 2010**

*TOTAL 2009 Year End NET PATIENT SERVICE REVENUE	2010 PROVIDER AGENCY DUES	Check Rate Below
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 10 Million	\$ 10,200	
10,000,001 to 15 Million	\$ 12,000	
15,000,001 to 20 Million	\$ 13,000	
20,000,001 to 25 Million	\$ 13,750	
25,000,001 to 30 Million	\$ 14,750	
30,000,001 to 35 Million	\$ 15,750	
35,000,001 to 40 Million	\$ 16,500	
Over 40 Million	\$ 17,500	

\* **Net Patient Service Revenue** = Total Charges minus contractual allowances for all patient revenue for licensed offices included in your dues calculation (home health agency, health care service firm and/or hospice).

**New applicants** in operation for more than one (1) year must submit proof of prior year's financials, such as copies of tax returns, audited financial statements or cost reports, and certify that the information provided is true and accurate. Home care entities in operation for less than one (1) year must submit other available financial proofs acceptable to the Home Care Association, and certify that the information provided is true and accurate.

**PAYMENT AGREEMENT**

Contributions or gifts to the Home Care Association of New Jersey 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. That percentage of dues used for lobbying by the Home Care Association of New Jersey is not deductible as a business expense. The non-deductible percentage of dues is estimated to be approximately 10%.

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 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.

**Authorized Signature**

**Date**

***METHOD OF PAYMENT***

Check      Check Number \_\_\_\_\_

Visa       MasterCard       American Express

Annual Amount Due \_\_\_\_\_ Amount of First Payment \_\_\_\_\_

CREDIT CARD NUMBER \_\_\_\_\_

Expiration Date \_\_\_\_\_ CCV# \_\_\_\_\_

Name on Card \_\_\_\_\_ Signature \_\_\_\_\_

Address of Cardholder \_\_\_\_\_

**RETURN APPLICATION, PAYMENT INFORMATION, STATEMENT OF ETHICAL VALUES, AND COPY OF LICENSE(S) TO:**

**Home Care Association of NJ - Attention: Donna Weiss  
485D Route 1 South, Suite 210, Iselin, NJ 08830  
Phone: 732-877-1100 Fax: 732-877-1101**