



HOME CARE, HOSPICE & PALLIATIVE CARE ALLIANCE OF NEW HAMPSHIRE

2019 Membership Form – *For Home Care And Hospice Agencies*

Agency Name _____

DBA – if any _____

Physical Address* _____

Town, State Zip _____

Mailing Address _____

Town, State Zip _____

Telephone _____

Toll-Free number _____

Administrative Fax _____

Referral Fax _____

Website _____

Number of office locations serving New Hampshire _____

Attach additional pages for all office locations serving New Hampshire

Checklist for Membership Application

- Application signed by the Agency's CEO
- Completed Dues Computation Form signed by the Agency's CEO
- Agency's audited financial statements for most recent fiscal year, if requested.

2019 Agency Member Application

Agency Information

Type of Provider (check all that apply)		Affiliation (check all that apply)	
<input type="checkbox"/>	Medicare-certified Home Care Agency	<input type="checkbox"/>	NAHC member
<input type="checkbox"/>	Medicare-certified Hospice Agency	<input type="checkbox"/>	VNAA member
<input type="checkbox"/>	Hospice House	<input type="checkbox"/>	NHPCO member
<input type="checkbox"/>	State licensed Home Health Care Provider	<input type="checkbox"/>	HCAOA member
<input type="checkbox"/>	State licensed Home Care Service Provider	<input type="checkbox"/>	Joint Commission accredited
<input type="checkbox"/>	Home Infusion Provider	<input type="checkbox"/>	CHAP accredited
<input type="checkbox"/>	Other	<input type="checkbox"/>	ACHC accredited

Ownership	Classification
<input type="checkbox"/> For-Profit	<input checked="" type="checkbox"/> Corporation
<input type="checkbox"/> Non-Profit	<input type="checkbox"/> LLC
Estimated Services Provided in 2018	
# Unduplicated clients served _____	<input type="checkbox"/> Individual/Sole-proprietor
# of visits (all services combined) _____	<input type="checkbox"/> Hospital -based
#number of employees _____	<input type="checkbox"/> Health System
# miles traveled by direct care staff _____	<input type="checkbox"/> Franchise
# Hospice volunteer hours _____	
# of volunteers (total from all programs) _____	

Agency Services by Payer	
<input type="checkbox"/> Medicare Skilled Nursing	New Hampshire Choices for Independence
<input type="checkbox"/> Medicare Rehabilitation Therapy	<input type="checkbox"/> (CFI) Nursing
<input type="checkbox"/> Medicaid Skilled Nursing	<input type="checkbox"/> (CFI) Home Health Aide
<input type="checkbox"/> Medicaid Rehabilitation Therapy	<input type="checkbox"/> (CFI) Personal Care
<input type="checkbox"/> Medicaid Private Duty Nursing	<input type="checkbox"/> (CFI) Homemaker
<input type="checkbox"/> Commercial Insurance Skilled Nursing	
<input type="checkbox"/> Commercial Insurance Rehabilitation Therapy	Private Pay
<input type="checkbox"/> Medicare Hospice	<input type="checkbox"/> (PP) Nursing
<input type="checkbox"/> Medicaid Hospice	<input type="checkbox"/> (PP) Home Health Aide
<input type="checkbox"/> Commercial Insurance Hospice	<input type="checkbox"/> (PP) Personal Care
<input type="checkbox"/> Title III & XX services	<input type="checkbox"/> (PP) Homemaker
<input type="checkbox"/> Palliative Care services	

2019 Agency Member Application

Agency Contacts

Administrative Contacts	<i>Name, title</i>	<i>E-mail Address</i>
Executive Director/CEO		
Executive Administrative Assistant		
Financial Manager/CFO		
Human Resources Manager		
IT/IS Manager		
Marketing/ Public Relations		
Quality Director/ CQI Manager		
Home Care Contacts	<i>Name, title</i>	<i>E-mail Address</i>
Clinical Director		
Rehab Therapy Director/ Manager		
Behavioral Health Manager		
Education Coordinator		
Home Health Aide Supervisor		
Private Duty Manager		
CFI Manager		
Lymphedema Contact		
Home Care Social Work Supervisor		
Hospice Contacts	<i>Name, title</i>	<i>E-mail Address</i>
Hospice Administrator		
Hospice Medical Director		
Bereavement Coordinator		
Hospice Volunteer Manager		
Chaplain		
Hospice Social Work Supervisor		

2019 Agency Member Application

Dues

Agency Membership dues are based on total gross revenues for all licensed entities doing business in New Hampshire for the organization's most recent fiscal year. **Dues amounts vary based on agency type.** Please complete the table below, using the computations found in Appendix A, to calculate Provider Membership dues, select a payment option, **and sign and return the completed application form with initial payment BEFORE January 1 to: Home Care, Hospice & Palliative Care Alliance of New Hampshire, 8 Green Street, Suite 2, Concord, NH 03301.**

Revenues are defined as follows for purposes of determining dues. The dues for Agency Members that provide services in more than one state will be based on those revenues derived from home care services delivered in New Hampshire only.

Dues calculated on the following:			
Include patient, third party, federal or state income from the following services:		Exclude income and revenue from these sources	
Intermittent home health visits	Personal care services	Fundraising revenues	Family planning
Private duty care	IV therapy	Donations/bequests	Meals on Wheels
Hospice (including Hospice House)	Respiratory therapy	United Way	Adult day care
Homemaker services	Case management	Town/county funding	Child day care
Palliative care	In- home nutritionist services	Home medical equipment	Transportation
Adult in-home care	Maternal & child health visits	MCH clinics	Outpatient clinics

Dues Calculation

- A. Date of most recent fiscal year: _____
- B. Enter total NH gross revenue for most recent fiscal year \$ _____ **Required**
- C. Calculate dues amount based on the attached dues table (appendix a) \$ _____ **Total amount due**

Dues amounts vary based on agency type. Refer to the table, appendix A, for categories

Payment Options

Enter total amount due (line C from above)

\$

Single payment

Payment of total annual dues due by Jan 1, 2019

\$

Two payment option

Calculate: divide total amount by two (2)

Payment due Jan 1 and July 1

\$

Four payment option

Calculate: Divide total amount by four (4)

Payments due Jan 1, April 1, July 1 and October 1

\$

**** Option not available to new members**

Please note that new members joining in January have a two payment plan available.
New members joining mid-year must pay their prorated dues in one payment.

Credit Card Option

Automatic and annual payments can be paid by credit card. **A 3.5% fee will be applied.**

Check here if you would like to be provided with a separate form for credit card processing. Credit cards can also be taken over the phone at 603-225-5597.

This section must be completed and signed by the Agency's executive director or chief executive officer.

Medicare Fraud/Abuse Certification

Have you or your organization been convicted of or pleaded guilty to charges of Medicaid or Medicare fraud and/or abuse or other illegal activity during the past two years? **Yes** **No**

If yes, please describe the situation and present status on a separate sheet of paper and include it with your returned application.

Certification of Application

I hereby signify that I have read the current Home Care, Hospice & Palliative Care Alliance of New Hampshire Provider Membership and Dues Policies including the Alliance's Code of Ethics, as adopted by the Board of Directors, and agree to abide by these policies. I further certify that the information included in this application is complete and accurate to the best of my knowledge.

Agency

Executive Director/CEO Signature

Date

Appendix A

2019 DUES TABLE

Gross Revenues from the provider's most recently completed Fiscal Year*	Medicare-certified Home Health & Hospice	Medicare-certified Home Health Only	Medicare-certified Hospice Only	Non-certified Home Health or Home Care Service Provider (NH-licensed 809s or 822s)	Palliative Care Service Providers, Affiliate members or Individuals
Up to \$275,000	\$1,362.00	\$1,300.00	\$1,300.00	\$1,238.00	
\$275,000 - \$1,375,000	Revenue x .00495	Revenue x .00473	Revenue x .00473	Revenue x .0045	
\$1,375,000 - \$2 Million	\$6,808.00	\$6,498.00	\$6,498.00	\$6,189.00	
\$2,000,001 - \$3 Million	\$7,427.00	\$7,090.00	\$7,090.00	\$6,752.00	
\$3,000,001 - \$4 Million	\$8,045.00	\$7,680.00	\$7,680.00	\$7,314.00	
\$4,000,001 - \$5 Million	\$8,664.00	\$8,270.00	\$8,270.00	\$7,876.00	
\$5,000,001 - \$6 Million	\$9,284.00	\$8,862.00	\$8,862.00	\$8,440.00	
\$6,000,001 - \$8 Million	\$9,901.00	\$9,451.00	\$9,451.00	\$9,001.00	
\$8,000,001 - \$10 Million	\$10,522.00	\$10,043.00	\$10,043.00	\$9,565.00	
\$10,000,001 - \$12 Million	\$11,140.00	\$10,633.00	\$10,633.00	\$10,127.00	
\$12,000,001 - \$15 Million	\$11,759.00	\$11,225.00	\$11,225.00	\$10,690.00	
\$15,000,001 - \$20 Million	\$12,377.00	\$11,815.00	\$11,815.00	\$11,252.00	
> \$20 Million	\$12,997.00	\$12,406.00	\$12,406.00	\$11,815.00	
Palliative Care Institutional Providers					\$1,200.00
Palliative Care Practices					\$1,200.00
Affiliate Members					\$325/\$575
Individual Members					\$150.00