Northeastern New York Chapter | **Provider Application for Chapter Membership 2015-16**

Providers must be members of HCP at the State level in order to be eligible for Chapter participation.

❑ **New Member** ❑ **Renewing Member**

Organization Name:____

d/b/a:______________________________ Year Established:______________________

Address:____

City:______________________State:________________Zip:________________

Phone:______________________________ Fax:______________________________

Main Contact:______________________________ Title:______________________________

E-mail Address: ____

Corporate type: (check one) ❑ Not-for-profit ❑ Proprietary

Chapter 2015/2016 Dues

Provider membership for each organization in the Northeastern New York Chapter of the New York State Association of Health Care Providers, Inc. (HCP) includes all related New York State home care corporations, subsidiaries and other entities under common ownership and/or management.

Annual Dues for Northeastern New York Chapter Provider membership are $200.

Note: First-time members who join mid-year are pro-rated for the remainder of the dues year.
The Northeastern New York Chapter dues year runs November 1 through October 31.

Payment

All members are encouraged to satisfy their dues obligation in entirety at the start of the dues year.

Total Due: ______________________ Amount Enclosed: ______________________

Make check payable to: Northeastern New York Chapter of the New York State Association of Health Care Providers, Inc.

Note: Chapter dues are not deductible as a charitable contribution for federal tax purposes, but may be deductible as a business expense as well as an allowable Medicare expense. However, in accordance with Section 13222 of OBRA 1993 (Denial of the Deduction for Lobbying Expenses), 9% of your membership dues are not tax deductible as ordinary and necessary business expenses.

Signature: ____

Title: ____

Thank you for joining the Northeastern New York Chapter. Please be sure to complete both sides of this application and return with payment to: HCP Northeastern New York Chapter, c/o Kathy Liddell, North Country Home Services, Inc., 18 Montcalm St., Suite 1, Ticonderoga, NY 12883.

Please call any of the HCP Northeastern New York Chapter Board Members with any questions.

President: Debra Obenhoff, Home Helpers and Direct Link, 518. 584.5885
Secretary: Karen Clark, Home Health Care Partners, 518.842.6718
Treasurer: Kathy Liddell, North Country Home Services, Inc., 518.585.9820

HCP Northeastern New York Chapter
Provider Application for Chapter Membership 2015-16

Instructions

Complete this section for each office of your organization where you would like to receive an extra mailing. Please copy this page, complete and attach for any additional locations. Please type or print neatly.

Organization Name:____

d/b/a:_______________________________ Year Established:____________________

Address:____

City:____________________State:________________Zip:________________

Phone:_______________________________ Fax:_______________________________

Main Contact:_______________________________ Title:_______________________________

Additional Contact: _______________________________ Title: _______________________________

Should this office receive information sent to all Chapter members?

- ❑ Yes (note: information will go to 1st contact)
- ❑ No

What type of office is listed on this form? (check one)

- ❑ Corporate Headquarters
- ❑ Franchise
- ❑ Main Office
- ❑ Branch Office
- ❑ Recruiting Office
- ❑ Satellite Office
- ❑ Other:________________________

What type of provider is listed on this form? (check one)

- ❑ CHHA
- ❑ LHCSA
- ❑ LTHHCP
- ❑ Hospice
- ❑ Licensure exempt
- ❑ License pending
- ❑ HME/DME
- ❑ Pharmacy
- ❑ Special Purpose CHHA
- ❑ AIDS LTHHCP
- ❑ Other:________________________

Is this office accredited? (check all that apply)

- ❑ JCAHO
- ❑ CHAP
- ❑ Other:________________________

Organization Name:____

d/b/a:_______________________________ Year Established:____________________

Address:____

City:____________________State:________________Zip:________________

Phone:_______________________________ Fax:_______________________________

Main Contact:_______________________________ Title:_______________________________

Additional Contact: _______________________________ Title: _______________________________

Should this office receive information sent to all Chapter members?

- ❑ Yes (note: information will go to 1st contact)
- ❑ No

What type of office is listed on this form? (check one)

- ❑ Corporate Headquarters
- ❑ Franchise
- ❑ Main Office
- ❑ Branch Office
- ❑ Recruiting Office
- ❑ Satellite Office
- ❑ Other:________________________

What type of provider is listed on this form? (check one)

- ❑ CHHA
- ❑ LHCSA
- ❑ LTHHCP
- ❑ Hospice
- ❑ Licensure exempt
- ❑ License pending
- ❑ HME/DME
- ❑ Pharmacy
- ❑ Special Purpose CHHA
- ❑ AIDS LTHHCP
- ❑ Other:________________________

Is this office accredited? (check all that apply)

- ❑ JCAHO
- ❑ CHAP
- ❑ Other:________________________

Thank you for joining the HCP Northeastern New York Chapter. Please be sure to complete both sides of application and return with payment.

OVER