**Western 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 2015-16 Dues

Provider membership for each organization in the Western 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 Western New York Chapter Provider membership are $300.**

Note: First-time members who join mid-year are pro-rated for the remainder of the dues year.
The Western 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: Western 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:** _____

**Date:**_____

**Thank you for joining the Western New York Chapter. Please be sure to complete both sides of this application and return with payment to:** HCP Western New York Chapter, c/o Sean Lewis, New Frontiers in TBI/Allwel, 41 Columbia St., Buffalo, NY 14204.

**OVER**

**HCP Western 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:_____

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d/b/a:_____ Year Established:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____ Fax:_____

Main Contact:_____ Title:_____

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