NYS Association of Health Care Providers
Representing Home & Community-Based Care

Allied Member Contract 2016-17

❒ New Member ❒ Renewal Date: _____

HCP Allied Membership Dues

This application is for annual HCP membership at the State level. **Allied members must be members of HCP at the State level in order to be eligible for local HCP Chapter membership.**

HCP offers Allied membership to foundations, academic institutions, and other associations. These organizations either work in partnership with the home care industry or have common interests. HCP membership enables them to take advantage of the advocacy efforts, information and benefits of their membership in HCP.

Any organization that joins as an HCP Allied member that has an affiliated home care agency may NOT provide HCP Member benefits to their affiliated agency(s) or association members, including distribution of HCP e-publications, Member Alerts and other HCP communications. The affiliated home care agency(s) must join HCP as a Provider member and pay dues based on their agency's revenues as indicated on the HCP Provider membership contract.

2016/17 HCP Allied Member Dues: $1,350 per year

HCP Membership is for one full year, November 1, 2016 – October 31, 2017. Allied member dues are NOT prorated.

NOTE: HCP dues are not deductible as a charitable contribution for Federal tax purposes, but may be deductible as a business 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.

_____
Organization Name

_____
Type of Business

_____
Address

_____
City/State/Zip

_____
Main Phone Main Fax

_____
Key (Main) Contact/Title

_____
Email Phone

_____
Additional Membership Contact/Title

_____
Email Phone

Contract Agreement and Signature

Membership and its benefits will not be granted if signed contract and payment are not received. Renewing HCP Allied members must be members in good standing at the State level and all dues must be paid in order to participate in HCP Chapter programs and events.

I agree to satisfy my dues obligation according to the terms of this contract, and I agree to receive information and announcements from HCP and its affiliates via fax and email.

Print Key Contact Name: _____

Key Contact Signature: _____

Date: _____

HCP Dues Payment

Please choose ONE payment option:

CHECK (payable to HCP)
❒ Full ❒ Semi-annual

CREDIT CARD (please complete credit card section below)
❒ Full ❒ Semi-annual automatic*

Amount enclosed: _____

Payment plans are available as a courtesy. **Members remain obligated for the entire dues amount.** Members that do not submit payments within 15 business days of the due date as established by the payment plan will have their HCP membership suspended until full payment is received. Signature on this contract constitutes agreement with this policy.

***Automatic credit card payments will be charged 5 business days prior to the due date so payments can be fully processed by the due date. Members with automatic payments will NOT receive an invoice prior to the due date; a receipt will be sent after the payment has been applied.**

Credit Card: ❒ Visa ❒ Master Card ❒ Discover ❒ AMEX

Card Number _____

Expiration Date (MM/DD) _____ Security Code ____
(3-4 digit code on front/back of card)

Print Cardholder Name _____

Cardholder Signature _____

Please fax to 518.463.1606; scan & email to hcp@nyshcp.org (credit card payments only)
or mail to HCP, 20 Corporate Woods Blvd., 2nd Floor, Albany, NY 12211