Provider Member Contract 2023-24

☐ New Member ☐ Renewal Date: _____

The New York State Association of Health Care Providers, Inc. (HCP) is a trade association representing home and community-based care providers across New York State through advocacy, information and education.

HCP 2023-24 membership is for one full year, from November 1, 2023 – October 31, 2024.

Provider members must be members of HCP at the State level in order to be eligible for local HCP Chapter membership.

Please select your dues category based on your agency's total revenues from your most recent fiscal year generated from home care programs, companion, consumer directed, staffing and any other home and community-based-related services provided in New York State.

- Agencies with related home care corporations, subsidiaries and common ownership and/or management agreements/arrangements must include revenues from all entities in their dues calculation. The total dues calculation also includes revenues from other entities under a management agreement regardless of which entity is applying for membership.

- Agencies affiliated with vendor/services companies that are HCP Associate/Allied members must join as a Provider member based on their agency's revenues as indicated above and may not receive HCP member benefits through their affiliated organization's Associate/Allied membership.

- Agencies that are independently incorporated but part of a hospital and/or medical group should calculate their dues category based solely on their independent corporation.

To ensure that HCP's dues are fair and equitable, with all members paying dues in the appropriate dues category, and to ensure that HCP is operating in accordance with generally accepted, standard business practices, members are asked to voluntarily submit with their contract a financial statement(s) from their most recent fiscal year OR a letter from their accountant certifying that the agency's revenues fall into the selected Provider dues category. All information will be kept strictly confidential and HCP will not disclose this information for any purpose outside of the Association.

HCP Dues Categories and Annual Dues

Less than $250,000	$ 1,700	$20M-$34.99M	$12,900
Less than $500,000	$ 2,695	$35M-$49.99M	$14,035
$501,000-$999,999	$ 3,510	$50M-$74.99M	$16,180
$1M-$3.99M	$ 5,185	$75M-$99.99M	$17,500
$4M-$7.99M	$ 6,410	$100M-$149.99M	$18,880
$8M-$11.99M	$ 8,050	$150M-$249.99M	$20,425
$12M-$15.99M	$10,300	$250M-$349.99M	$24,585
$16M-$19.99M	$12,120	$350M+	$28,685

HCP 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.

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Please provide the following information so that we may serve you better.

Organization Name and DBA, if applicable

Mailing Address, City, State, Zip

Main Contact and Title

Email

Phone

Agency Website

Which of the following programs do you participate in?

☐ NHTD ☐ TBI ☐ OMH ☐ OPWDD
☐ SOFA ☐ PACE ☐ CDPAP
☐ Long-Term Home Health Care Program (LTHHCP)
☐ Other (please specify)

_____

Is your agency a non-profit organization?

☐ Yes ☐ No

How many licenses does your agency hold?

_____

Please list any additional staff with the following titles so that we may fully serve your organization: CEO, CFO, COO, Administrator, Director of Patient Services, RN Supervisor, Human Resources Manager. You can also email hcp@nyshcp.org with your roster.

Name, Title, Email

Name, Title, Email

Name, Title, Email

Name, Title, Email

HCP Dues Categories and Annual Dues

Please check the appropriate dues category based on agency revenue.

☐	Less than $250,000	$ 1,700	☐	$20M-$34.99M	$12,900
☐	Less than $500,000	$ 2,695	☐	$35M-$49.99M	$14,035
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HCP's Principles of Conduct

(required as per the HCP Board of Directors)

As providers of health care services, we consider the care, needs, worth and dignity of the patient to be of paramount importance and will endeavor as individual members to ensure respect for the rights of patients, including:

1. *Delivery of services to our clients and patients in accordance with standards of business practice and health care.*
2. *Respect for the right of privacy of patients and protection of the confidentiality of all patient medical and financial information.*
3. *Assurance of continuity of care of our patients.*

We will do all that is necessary to develop and implement plans for corporate compliance that assure conformity with all local, State and Federal rules of law and professional practices. We will maintain the highest standards of integrity in advertising, sales promotion, and marketing and will not knowingly misrepresent our services or employees.

Please sign to confirm that the applying agency has done the following:

I have read and understood the **HCP Principles of Conduct** and understand that as a member of HCP, I agree to abide by these Principles. I certify that the dues category selected reflects my agency's total revenues generated from home care programs, staffing and other related home and community-based services provided in New York State from my agency's most recently completed fiscal year. I understand that my agency is obligated for the entire dues amount. I understad that organizations are responsible for full dues amount even in the event of an ownership transition. I agree to receive information from HCP, affiliates, and Associate members.

Signature on this contract constitutes agreement with this policy.

_____

Main contact signature & date

HCP Dues Payment

TOTAL 2023-24 DUES: _____

Amount enclosed: _____

Please choose ONE payment option:

☐ **Check** (payable to HCP) **(PREFERRED)**
☐ Full ☐ Semi-annual ☐ Quarterly

☐ **Bank to Bank Transfer** (EFT) Routing # 221371372, Checking Acct. # 128006269 (**PREFERRED)**
☐ Full ☐ Semi-annual ☐ Quarterly

☐ **Credit card (**please complete credit card section below)
☐ Full ☐ Semi-annual automatic* ☐ Quarterly automatic*

Type of card: _____

Card Number_____ Expiration _____ Security Code _____

Print Cardholder Name_____ Cardholder Signture _____

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.

**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.*