MINNESOTA HOME CARE ASSOCIATION
The Voice of Home Care

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2017 PROVIDER APPLICATION

The information on this form is used for the term of one year from January 1, 2017 through December 31, 2017, to calculate your agency's membership dues, create your company's profile in our database system, and to be listed on our membership directory. Complete and return this form to MHCA.

COMPANY INFORMATION

Agency Name:	Phone:
	Fax:
Business Physical Address/City/State/Zip:	Toll-Free:
	Website:
	Email:
Business Mailing address/City/State/Zip: *(if different from physical address)*	County:
	MHCA Region *(Refer to MHCA's Region Map)*:

DUES COMPUTATION

Dues are assessed based on the home care agency/program's adjusted revenue that was received from the last complete fiscal year. **Adjusted revenue** includes all dollars, regardless of source, obtained by your organization for providing home care services; it is the gross revenue less all discounts or allowances (expected amount due from payer).

- ☐ **Maximum Dues:** If adjusted revenue exceeds $2 million, then pay the flat rate of **$5,200.**
- ☐ **Variable Dues:** If adjusted revenue is more than $268,500 but less than $2 million, **multiply your adjusted revenue by .0025905,** then round-it to the nearest dollar. This will be your dues rate.
- ☐ **Minimum Dues:** If adjusted revenue is less than $268,500, then pay the flat rate of **$700.**

Dues or gifts to MHCA are not tax deductible as charitable contributions for income tax purposes. However, they may be tax deductible as ordinary and necessary business expenses subject to federal restrictions imposed on expenses for association lobbying activities. MHCA estimates that the non-deductible portion of your **dues allocation for lobbying is 20%.**

New Member Discount: New members (agencies who have not paid MHCA dues within 3+ years) qualify for a one year, 50% reduction in dues or a proration, which-ever is lessor. Dues must be paid in full at the time of application to receive the discount.

Dues are nonrefundable.

DUES CALCULATION

ADJUSTED REVENUE:	**$**	
2017 MEMBERSHIP DUES	**=**	**$**
NEW MEMBER DISCOUNT	**=**	**($)**
TOTAL	**=**	**$**

New Member Discount must be paid in full at the time of application to receive discount.

PAYMENT METHOD

☐ Bill Me ☐ Check ☐ Credit Card

Credit card payments will be assessed a 3% credit card usage fee.

Credit Card #:	
Exp. Date:	Security Code:
Name on Card:	
Card Holder Signature:	

I HEREBY CERTIFY THAT THE REVENUE REPORTED IS CORRECT.

Signature:

Print Name:

Date:

Agency Name:

PROVIDER SERVICES

Counties Your Agency Serves within MN:

Provider Type: *(Check all that apply)*

- ☐ Home Care
- ☐ Home Care Nursing *(formerly PDN)*
- ☐ Housing with Services
- ☐ Hospice
- ☐ Palliative Care
- ☐ PCA Traditional
- ☐ PCA Choice

Structure: *(Check all that apply)*

- ☐ County Public Health
- ☐ Hospital Affiliated
- ☐ Nursing Home-Based
- ☐ Free Standing
- ☐ Private Non-Profit
- ☐ Proprietary *(for profit)*

Certification/Accreditation: *(Check all that apply)*

- ☐ ACHC
- ☐ CHAP
- ☐ Joint Commission
- ☐ Medicare Certified
  Home Care Provider #
  _____

Payment Methods Accepted: *(Check all that apply)*

- ☐ HMO/Managed Care
- ☐ Medical Assistance (MA)
- ☐ Medicare (MED)
- ☐ Private Insurance (INS)
- ☐ Private Pay (PP)
- ☐ Sliding Fee (SF)
- ☐ Veterans Administration (VA)

Waiver Program Services:

- ☐ AC
- ☐ CAC
- ☐ CADI
- ☐ DD
- ☐ EW
- ☐ LTCC
- ☐ PDN
- ☐ TBI

License Class: *(Check all that apply)*

- ☐ Comprehensive *(License #_____)*
- ☐ Basic *(License #_____)*
- ☐ Hospice
- ☐ Home Management
- ☐ 254D
  - ☐ Basic Support Services
  - ☐ Intensive Support Services

Services Offered: *(Check all that apply)*

- ☐ Apnea Monitoring (AM)
- ☐ Assisted Living (AL)
- ☐ Case Management (CM)
- ☐ Chore
- ☐ Companion (COM)
- ☐ Dialysis (DIA)
- ☐ Durable Medical Equipment (DME)
- ☐ Enterostomal Therapy (ET)
- ☐ Extended Hours Nursing
- ☐ Health Promotion (HP)
- ☐ Home Health Aide (HHA)
- ☐ Homemaker (HM)
- ☐ Hospice (HOS)
- ☐ Integrative Therapies (CAM)
- ☐ IV Therapy (IV)
- ☐ Live-in (LI)
- ☐ Maternal Child Health (MCH)
- ☐ Mental Health (MH)
- ☐ Occupational Therapy (OT)
- ☐ Over Night Care
- ☐ Palliative Care
- ☐ Pediatrics
- ☐ Personal Care Assistant (PCA)
- ☐ Personal Emergency Response Services (PERS)
- ☐ Pharmacist
- ☐ Physical Therapy (PT)
- ☐ Psychiatric Nursing
- ☐ Registered Dietician
- ☐ Respiratory Therapy (RT)
- ☐ Respite (RES)
- ☐ Skilled Nursing (SN)
- ☐ Social Work (SW)
- ☐ Speech Therapy (ST)
- ☐ Telehealth
- ☐ Transportation
- ☐ Unlicensed Personnel
- ☐ Ventilator (VEN)
- ☐ Wound Care Specialties

Agency Name:

THE DATA BELOW WILL *ONLY* BE USED FOR MHCA'S REFERENCE:

Number of Employees *(full-time)*:	**State House District** *(if known)*:
Number of Employees *(part-time)*:	**State Senate District** *(if known)*:
Number of Employees *(casual)*:	**US Congressional District** *(if known)*:
Number of Clients/Average Daily Census *(for past fiscal year)*:	

Are You a Member of the Following Associations?

- National Association for Home Care (NAHC) ☐ Yes ☐ No
- Visiting Nurse Association of America (VNAA) ☐ Yes ☐ No
- Care Providers of Minnesota ☐ Yes ☐ No
- LeadingAge Minnesota ☐ Yes ☐ No
- Minnesota First Provider Alliance ☐ Yes ☐ No
- MN Network of Hospice and Palliative Care (MNHPC) ☐ Yes ☐ No

PRIMARY ADMINISTRATIVE CONTACTS

It is recommended that you assign an individual to be the agency's **Voting Representative and Primary Contact Person.** This person will receive all mailings, emails, ballots and dues renewals on behalf of the agency.

MAIN CONTACT PERSON'S/VOTING REPRESENTATIVE'S INFORMATION

Name:	
Alternate Address if Different from Agency's Address	
Direct Phone:	**Alternate Phone:**
E-mail Address:	

ALTERNATE REPRESENTATIVE'S INFORMATION *(Optional)*

Name:	
Alternate Address if Different from Agency's Address	
Direct Phone:	**Alternate Phone:**
E-mail Address:	