



# Membership Application

## 2008 / 2009

**Step 1**

Agency Name: \_\_\_\_\_ Home Care/Hospice Licensure No.: \_\_\_\_\_

Parent Entity /Legal Owner (if applicable): \_\_\_\_\_

Administrator: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Web Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Number of Employees: (all types, all offices, all categories) \_\_\_\_\_

Ownership:     Public             Private Non-Profit     Private For-Profit     Hospital-Based/Public  
                    Hospital-Based/ Private Non-Profit     Hospital-Based/ Private For-Profit

- Is Your Home Care Agency Medicare-Certified?             YES             NO
- Is Your Hospice Agency Medicare-Certified?             YES             NO
- Is Your Agency Accredited? If yes, by whom? \_\_\_\_\_  YES             NO
- Is Your Agency a Provider of Medicaid PCS Services?     YES             NO
- Is Your Agency a Provider of Medicaid CAP/DA?             YES             NO
- Is Your Agency a Provider of Medicaid PDN?             YES             NO
- Is Your Agency a Provider of Behavioral Health?             YES             NO
- Is Your Agency a Member of NAHC?             YES             NO
- Is Your Agency a Member of NHPCO?             YES             NO
- Is Your Agency a Member of Carolinas Center for Hospice?  YES             NO
- Is Your Agency a Member of AA Homecare?             YES             NO
- Is Your Agency a Member of NCAMES?             YES             NO

Additional E-Mail Addresses for the Above Office ONLY: (See page 4 to include E-Mail addresses for other office locations)

1. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
2. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
3. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
4. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
5. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
6. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
7. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
8. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
9. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
10. Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**STEP 2**

How many licensed offices does your parent entity operate in North Carolina that provides any type of in-home service, hospice, or community-based care? \_\_\_\_\_ If your parent entity has more than one office operating in North Carolina, other than the office listed in STEP 1, be sure to complete the form on the back page entitled, "Additional Office Membership".

**The number of offices you indicate on the form, should match the number of licensed sites on record at the Division of Health Services Regulation. You may check this by going to**

<http://www.ncdhhs.gov/dhsr/>

STEP 3

Membership Dues Calculation

Dues are based upon a parent entity's gross revenue as defined below.

**Definition of Gross Revenue**

Gross revenue is defined as the parent entity's revenue for the most recent fiscal year, from all offices in North Carolina, which provide in-home and community-based services of any kind. **All agencies that are related by common ownership or control shall be treated as a single member for that purpose.** Revenue is regardless of payor source. The following services in Section A-G must be included when calculating gross revenue. Please indicate gross revenue for each service category and total where indicated. **(When calculating gross revenue, you may exclude the following items: contractual adjustments, bad debts; investment income, charitable donations, funds raised through special events and philanthropic dollars).** As always, this information will be kept strictly confidential.

**\*\*\*Note\*\*\***

**It is imperative that you answer each revenue section as accurately as possible. If a question does arise, additional information and verification may be necessary.**

**A. Intermittent Home Care Visits/ Hourly or Per Unit Home Care Services**

This includes, **but is not limited to**, revenue received from: Nursing, Aide, PT, SLP, OT, MSW, nutrition, sitter, companion, homemaker, respite, home medical equipment (HME/DME), and supplies. Revenue is **regardless** of payor source, including Medicare, Medicaid, insurance, and private pay. Also include IPP, PCS and CAP services (include non-mental health CAP services such as CAP-DA, CAP-C, CAP-AIDS. CAP-MRDD revenue should be reported in section G.)

**Gross Revenue received from services defined in A above is: \$ \_\_\_\_\_**

**B. Hospice Services**

This includes freestanding hospice in-patient and residential facility revenue and hospice routine home care services, regardless of place of service. *(Do not include in gross revenue any general in-patient care provided through contract by a hospital or nursing home. Also, do not include nursing home room and board charges for hospice nursing home patients.)*

**Gross Revenue received from services defined in B above is: \$ \_\_\_\_\_**

**C. Case Management Services**

This includes, but is not limited to: CAP case management, HIV case management, AIDS case management, and private case management services.

**Gross Revenue received from services defined in C above is: \$ \_\_\_\_\_**

**D. Supplemental Staffing Services**

This includes revenue generated from providing staffing to other home care agencies and assisted living facilities (including adult care homes and multi-unit assisted housing with services). *Do not include revenues generated from staffing ICF's, SNF's and hospitals.*

**Gross Revenue received from services defined in D above is: \$ \_\_\_\_\_**

**E. Infusion Services**

This includes revenue generated from, but not limited to: pharmaceuticals, infusion equipment, and Medicaid HIT

**Gross Revenue received from services defined in E above is: \$ \_\_\_\_\_**

**F. Adult Day Health, Day Care and Transportation Services**

**Gross Revenue received from services defined in F above is: \$ \_\_\_\_\_**

**G. Mental Health Services**

This primarily includes CAP-MRDD, and any mental health service that requires a home care license for the provision of that service.

**Gross Revenue received from services defined in G above is: \$ \_\_\_\_\_**

**TOTAL for Sections A - G: \$ \_\_\_\_\_**

**Using the total from sections A - G, calculate your annual dues using the following scale**

<b>Membership Dues Scale</b>	<b>2007/08 DUES</b>	
<b>Gross Revenue (Sum of Sections A-G)</b>		If gross revenue is \$20,000,000 or more, calculate dues as follows:
\$ 1 - \$ 500,000	<b>\$ 700</b>	<b>Step 1A: (If Revenue is between \$20,000,000 - \$34,999,000)</b>
\$ 500,001 - \$ 1,500,000	<b>\$ 1,400</b>	Dollar amount above \$19,999,999 = _____ x .00015 = _____
\$ 1,500,001 - \$ 2,500,000	<b>\$ 2,100</b>	(a) (b)
\$ 2,500,001 - \$ 3,500,000	<b>\$ 2,900</b>	<b>OR:</b>
\$ 3,500,001 - \$ 4,500,000	<b>\$ 3,800</b>	<b>Step 1B: (If Revenue is 35,000,000 or more)</b>
\$ 4,500,001 - \$ 5,500,000	<b>\$ 4,800</b>	Dollar amount above \$19,999,999 = _____ x .0002 = _____
\$ 5,500,001 - \$10,000,000	<b>\$ 5,900</b>	(a) (b)
\$10,000,001 - \$19,999,999	<b>\$ 7,200</b>	<b>Step 2:</b>
		\$7,200 + (1A or 1B) from above = _____
		(Total Annual Dues)

**STEP 4**

**Verification of Revenue**

**In order for AHHC to verify your agency's gross revenue, you must choose one of the following methods:**

- A.** Submit an independent audited financial statement from your most recently ended fiscal year or;
- B.** Have an independent CPA or financial consultant (other than an employee or internal finance officer) verify your in-home service gross revenue by signing below, or:
- C.** If your parent entity is a hospital, the hospital's CFO may verify all their in-home service gross revenue by signing below, or;
- D.** If your parent entity's corporate office is located outside of North Carolina, the CFO from the corporate office may verify all their in-home service gross revenue from North Carolina, by signing below or;
- E.** If you are a county-based agency, the county finance manager may verify all their in-home service gross revenue by signing below.

**For The Person Authorized To Verify Gross Revenue:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 (please print)

Signature: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
 (include area code)

**STEP 5 - Payment**

*All membership dues must be paid in full.* Dues may be paid by check or credit card. Make checks payable to: Association for Home & Hospice Care of NC (AHHC), 3101 Industrial Drive, Suite 204, Raleigh, North Carolina 27609.

- I have enclosed a check in the amount of \$ \_\_\_\_\_ to cover our annual dues.
- Please charge my credit card in the amount of \$ \_\_\_\_\_ to cover our annual dues.
- In addition, our agency would like to make a voluntary contribution to AHHC's restricted Patient/Provider Defense & Media Fund of \$ \_\_\_\_\_. I understand this contingency fund is used to help defray the cost of any legal expenses and/or public relations cost associated with protecting the rights of our providers and the patients they serve (as deemed appropriate by AHHC's Board of Directors).

Visa\_\_\_\_\_ Mastercard\_\_\_\_\_ American Express\_\_\_\_\_ Discover\_\_\_\_\_

Account No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Address of Cardholder: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

## ADDITIONAL OFFICE MEMBERSHIP

*(Make copies of this form to list additional offices, if necessary)*

**Please Complete This Form If You Have More Than One Office Located in North Carolina.  
This Will Ensure That Each Office Receives All Member Benefits.**

Agency Name: \_\_\_\_\_ Home Care/Hospice Licensure #: \_\_\_\_\_

Administrator: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

Is this licensed site Medicare-Certified?  YES  NO

Does this site provide Medicaid PCS Services?  YES  NO

**Additional Staff E-Mails for this location:**

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Home Care/Hospice Licensure #: \_\_\_\_\_

Administrator: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

Is this licensed site Medicare-Certified?  YES  NO

Does this site provide Medicaid PCS Services?  YES  NO

**Additional Staff E-Mails for this location:**

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Home Care/Hospice Licensure #: \_\_\_\_\_

Administrator: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

Is this licensed site Medicare-Certified?  YES  NO

Does this site provide Medicaid PCS Services?  YES  NO

**Additional Staff E-Mails for this location:**

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

3101 Industrial Dr.  
Suite 204  
Raleigh ♦ NC ♦ 27609

♦ Phone  
919-848-3450  
♦ Fax  
919-848-2355  
♦ E-Mail  
info@homeandhospicecare.org  
♦ Website  
www.homeandhospicecare.org