2018 Provider Membership Application

STEP 1: PRIMARY CONTACT

*Election Ballot will be emailed to this contact
*Information will be used for the 2018 Directory

For each agency/branch you must complete the Provider Location & Licensure Form for accuracy of the Provider Directory

Organization___________________________________

Contact Person ________________________________

Title ____

Address ______________________________________

Suite___________ City __________________________

State ___________ Zip Code ______________________

Email ____

Phone ____

Fax ____

Website ______________________________________

☐ Facebook ☐ Twitter ☐ Linkedin

LICENSURE

License # **15__ __ __ __**

How many branches do you operate under this license #?

 # OF BRANCHES _____________

Indicate Branch locations on additional Provider Branch & Services Page

PSA License# ___________________________

PDN License # __________________________

Hospice License # **40 __ __ __ __**

Do you operate a Residential Hospice Facility?

☐ YES Where? ____________________________

LICENSE TYPE

☐ Home Health ☐Hospice ☐ Adult Day ☐ Palliative Care
☐ Personal Care Services ☐ Non-Medical In-Home Services
☐ Infusion ☐ Networking ☐ Organizational ☐ Affiliate ☐ Private Duty Nursing ☐ Personal Service Agency

OWNERSHIP (Type of Organization)

☐ For Profit ☐ Non-Profit

CLASSIFICATION:

☐ Corporation ☐ Hospital Based ☐ LLC
☐ Individual /Sole Proprietor ☐ Public Health Dept.
☐ Other

ACCREDITATION

Check all accreditations applicable to this membership

☐ ACHC ☐ CHAP ☐ JCAHO

☐OTHER ______________________________

AGENCY DATA

_______ Total Number of KY Branches

_______ Total Number of Licensed Providers

_______ Total Employees (Admin & Field)

MEMBER OF:

☐ National Association of Home Care (NAHC)
☐ National Hospice & Palliative Care Org (NHPCO)
☐ Home Care Association of America (HCAOA)
☐ Visiting Nurse Associations of America (VNAA)
☐ Leading Age KY
☐ Kentucky Physical Therapy Association (KPTA)
☐ Kentucky Rural Health Association (KRHA)
☐ Kentucky Association of Private Providers (KAPP)
☐ Other ________________________________

INSURANCE ACCEPTED /PAYER

☐COMMERCIAL INSURANCE_______________________

☐MEDICAID FFS

☐MEDICAID MANAGED CARE (Check all that apply)

☐Humana /Caresource ☐PassPort

☐Aetna ☐Anthem ☐Wellcare

☐ MEDICARE ☐ PRIVATE PAY ☐ WORKERS COMP

☐ VA ☐ OTHER__________

EMR SYSTEM USED: ____________________________

DME EQUIPMENT: _____________________________

MEDICAL SUPPLIES: ___________________________

☐WAIVER SERVICES (Check all that apply)

☐HC Waiver Service Provider ☐HC Waiver Case Management

☐Michelle P. Waiver ☐SCL ☐TBI

☐EPSDT Special Services (Check all that apply) ☐PT ☐ST ☐OT

OTHERS SPECIAL PROGRAMS AT THIS BRANCH

____

____

____

COMPLETE FOR EACH AGENCY / BRANCH LOCATION

2018 Provider Branches & Services

Photocopy this page as needed for each

❶ AGENCY/Branch Name:

____

LICENSURE

License # **15__ __ __ __**

How many branches do you operate under this license #?

 # OF BRANCHES ______________ BRANCH# ______OF_______

Indicate Branch locations on additional Provider Location Page

Hospice License # **40 __ __ __ __**

Do you operate a Residential Hospice Facility?

☐ YES Where? ____________________________________

LICENSE TYPE

☐ Home Health ☐ Hospice ☐ Adult Day ☐ Palliative Care
☐ Personal Care Services ☐ Non-Medical In-Home Services
☐ Infusion ☐ Networking ☐ Organizational ☐ Affiliate
☐ Private Duty Nursing ☐ Personal Service Agency

COUNTIES SERVED

☐ Adair	☐ Edmonson	☐ Knox	☐ Nicholas
☐ Allen	☐ Elliott	☐ Larue	☐ Ohio
☐ Anderson	☐ Estill	☐ Laurel	☐ Oldham
☐ Ballard	☐ Fayette	☐ Lawrence	☐ Owen
☐ Barren	☐ Fleming	☐ Lee	☐ Owsley
☐ Bath	☐ Floyd	☐ Leslie	☐ Pendleton
☐ Bell	☐ Franklin	☐ Letcher	☐ Perry
☐ Boone	☐ Fulton	☐ Lewis	☐ Pike
☐ Bourbon	☐ Gallatin	☐ Lincoln	☐ Powell
☐ Boyd	☐ Garrard	☐ Livingston	☐ Pulaski
☐ Boyle	☐ Grant	☐ Logan	☐ Robertson
☐ Bracken	☐ Graves	☐ Lyon	☐ Rockcastle
☐ Breathitt	☐ Grayson	☐ McCracken	☐ Rowan
☐ Breckinridge	☐ Green	☐ McCreary	☐ Russell
☐ Bullitt	☐ Greenup	☐ McLean	☐ Scott
☐ Butler	☐ Hancock	☐ Madison	☐ Shelby
☐ Caldwell	☐ Hardin	☐ Magoffin	☐ Simpson
☐ Calloway	☐ Harlan	☐ Marion	☐ Spencer
☐ Campbell	☐ Harrison	☐ Marshall	☐ Taylor
☐ Carlisle	☐ Hart	☐ Martin	☐ Todd
☐ Carroll	☐ Henderson	☐ Mason	☐ Trigg
☐ Carter	☐ Henry	☐ Meade	☐ Trimble
☐ Casey	☐ Hickman	☐ Menifee	☐ Union
☐ Christian	☐ Hopkins	☐ Mercer	☐ Warren
☐ Clark	☐ Jackson	☐ Metcalfe	☐ Washington
☐ Clay	☐ Jefferson	☐ Monroe	☐ Wayne
☐ Clinton	☐ Jessamine	☐ Montgomery	☐ Webster
☐ Crittenden	☐ Johnson	☐ Morgan	☐ Whitley
☐ Cumberland	☐ Kenton	☐ Muhlenberg	☐ Wolfe
☐ Daviess	☐ Knott	☐ Nelson	☐ Woodford

❷ CONTACT FOR THIS BRANCH

*Information will be used for the 2018 Directory

☐ Check here if contact information below is the same as listed under Primary Contact

Main Contact: ____________________________________

Title: ____________________________________

Branch Address: ____________________________________

____

Suite___________ City ____________________________

State ___________ Zip Code __________________________

Email ____________________________________

Phone ____________________________________

Fax ____________________________________

Website ____________________________________

☐ Facebook ☐ Twitter ☐ Linkedin

❸ SERVICES OFFERED AT THIS BRANCH

☐	Behavioral Health	☐	Home Medical Equipment	☐	Personal Care Services
☐	Bereavement/ Grief Counseling	☐	Licensed Practical Nursing	☐	Physical Therapy
☐	Case Management	☐	Maternal Health	☐	Private Duty Nursing
☐	CHHA Hourly	☐	Medical Social Services	☐	Psychiatric Nursing
☐	CHHA Live-in	☐	Medication Management	☐	Registered Dietitian
☐	Chronic Care Mngt	☐	Mobile Meals	☐	Respite Care
☐	Companions /Sitters	☐	Nursing	☐	Skilled Nursing
☐	Dementia Care	☐	Occupational Therapy	☐	Speech Therapy
☐	Emergency Response Systems	☐	Pediatric Hospice	☐	Supply only patients
☐	Geriatric Care Management	☐	Palliative Care	☐	Telehealth Monitoring
☐	Home Infusion / Intravenous Therapy	☐	Pediatric Care	☐	Transportation
☐	Home Health Aides	☐	Shift Nursing	☐	Ventilator Care

2018 Membership Categories

❶ FULL AGENCY MEMBERSHIP

This member category is open to any organization whose primary purpose is the delivery of direct health care services to persons in their place of residence or community-based outpatient setting.

A. LICENSED HOME HEALTH AGENCIES

Dues based on range of home health visits. See dues scale, based on visits per year.

•PLUS + $500 per additional license/provider number

•PLUS + Number of HCB Visits/Encounters x $.02 (up to $500 maximum)

Agencies that are a part of a corporation with multiple licenses/provider numbers in Kentucky have two options.

OPTION 1:

You may include all offices or locations in one membership by calculating dues based on the total number of chargeable home health visits made by all offices, plus $500 per additional provider/license number.

EXAMPLE- Offices 2 & 3 have separate license/provider #'s

Main Office	30,000 Annual Visits	Primary License	HCB Visits= 6,000
Office 2	25,000 Annual Visits	Addtl License $500	HCB Visits=5,000
Office 3	15,000 Annual Visits	Addtl License $500	HCB Visits=3,000
TOTAL	**70,000 Annual Visits**	**Addtl $1,000**	**HCB Visits=14,000**

Dues from range = $6,425
Addtl Licenses =$1,000
HCB Visits =$ 280 (14,000 X $ .02)
TOTAL DUES =$7,605

OPTION 2:

You may have memberships for each separate licensed office/provider number and pay separate dues for each of the Kentucky offices owned by the corporation. Membership will not be accepted unless all Kentucky offices are included.

B. HOSPICE & PALLIATIVE CARE AGENCIES

Dues: **$850 Annually**

C. OTHER DIRECT CARE ORGANIZATIONS

Dues: **$850 Annually**- regular rate for qualifying organizations

Dues: $**475 Annually-** discounted rate for a qualifying subdivision of a Home Health Agency or Other Direct Care Organization if parent company pays at regular rate

D. ADULT DAY HEALTH CENTERS

Dues: **$450 Annually**- for first licensed center and **$50 for each additional licensed center**. *(When a company owns multiple licensed adult day health centers, all licensed centers must be included in the membership.)*

E. Non-MEDICAL IN-HOME SERVICE ORGANIZATIONS PERSONAL CARE SERVICE AGENCIES

Dues: **$850 Annually**- Special two-year introductory rate of $475 per year. After paying two years at this rate, dues will revert to the regular yearly rate of $850.

❷ ASSOCIATE MEMBERSHIP

This member category is open to any organization which fosters the home care or in support of those delivering home care services in an Outpatient community-based setting and including but not limited to hospices, infusion services, private duty services and adult day health centers, personal care agencies, case management services and Durable Medical Equipment. This category is not engage in direct service delivery.

Associate Membership at a discounted rate is open to qualifying subdivisions of Full Agency members. Such subdivisions may be members in their own right with benefit applying to employees in that program by paying special, discounted Associate dues.

Dues: **$850 Annually**- regular rate for qualifying organization
$475 Annually- discounted rate for subdivisions of Full Agency Members

EXAMPLE:

	Annual Dues
XYZ Financial Consultants	$850
ASKE Medical Supply Co. (Independent Co.)	$850
ABB DME (a subdivision of AAA Home Health Agency, a Full Agency Member of KHCA)	$475

❸ NETWORKING MEMBERSHIP

Any person interested in Health Care, except an individual who is an employee or principle of an organization qualifying as a Full or Associate member shall not be accepted as a Networking member unless the employing agency is a current member in the appropriate class.

Dues: **$100 Annually**

2018 Membership Dues Calculation

STEP 2: LOCATE YOUR CATEGORY

Locate your membership category and check the corresponding dues rate. If paying more than one membership category, please attach a sheet with the complete information.

1 FULL AGENCY MEMBERSHIP

This member category is open to any organization whose primary purpose is the delivery of direct health care services to persons in their place of residence or community-based outpatient setting.

A. LICENSED HOME HEALTH AGENCIES

Agencies with multiple licenses/provider numbers must include all offices or locations using either Option 1 or Option 2. An example of each option can be found under the Membership Categories page.

DUES: Based on range of annual visits (see below) plus $500 for each additional license/provider number as well as two cents ($.02) per Home and Community-Based Waiver visits or encounters. DO NO count individual HCB units!

CHECK BOX	Membership Dues Visits Per Year	2018 DUES
	1 - 6,000	$850
	6,001 - 12,000	$1,550
	12,001 - 18,000	$2,475
	18,001 - 24,000	$3,375
	24,001 - 30,000	$4,250
	30,001 -36,000	$5,200
	36,001 - 50,000	$5,825
	50,001 - 100,000	$6,425
	1000,001 - OVER	$7,250

Dues based on range of visit	$
Number of additional license/provider Numbers __________ x $500	$
Number of HCB Visits __________ x .02 *(Up to maximum of $500)*	$

$____________
(1A) TOTAL HOME HEALTH DUES

B. HOSPICE AND PALLIATIVE CARE AGENCIES

Dues: $850 Annually

$____________
(1B) TOTAL HOSPICE & PALLIATIVE CARE AGENCY

C. OTHER DIRECT CARE ORGANIZATIONS

Dues: **$850 Annually**- regular rate for qualifying organizations

Dues: $**475 Annually-** discounted rate for a qualifying subdivision of a Home Health Agency or Other Direct Care Organization if parent company pays at regular rate.

Regular Rate	$850	$
Subdivision Discount	$475	$

$____________
(1C) TOTAL OTHER DIRECT CARE ORGANIZATIONS

D. ADULT DAY HEALTH CENTERS

Dues: **$450 Annually**- for first licensed center and **$50 for each additional licensed center**. *(When a company owns multiple licensed adult day health centers, all licensed centers must be included in the membership.)*

Adult Day Health Center	$450	$
Additional Licensed Centers __________ x $50		$

$____________
(1D) TOTAL ADULT DAY HEALTH CENTERS

E. NON-MEDICAL IN-HOME SERVICE ORGANIZATIONS PERSONAL CARE SERVICE AGENCIES

Dues: **$850 Annually**- Special two-year introductory rate of $475 per year. After paying two years at this rate, dues will revert to the regular yearly rate of $850.

Annually	$850	$
2-Year Introductory	$475	$

$____________
(1E) TOTAL NON-MEDICAL
IN-HOME SERVICE ORGANIZATIONS
PERSONAL CARE SERVICE AGENCIES

2018 Membership Dues Calculation

❷ ASSOCIATE MEMBERSHIP

This member category is open to any organization which fosters the home care or in support of those delivering home care services in an Outpatient community-based setting and including but not limited to hospices, infusion services, private duty services and adult day health centers, personal care agencies, case management services and Durable Medical Equipment. This category is not engage in direct service delivery.

Annually	$850	$
Subdivision Discount	$475	$

$____________
(2) TOTAL ASSOCIATE MEMBERSHIP

❸ NETWORKING MEMBERSHIP

Any person interested in Health Care, except an individual who is an employee or principle of an organization qualifying as a Full or Associate member shall not be accepted as a Networking member unless the employing agency is a current member in the appropriate class.

Annually	$100	$

$____________
(3) TOTAL NETWORKING MEMBERSHIP

ALL MEMBERS NOTE:

Corporate organizations owning businesses which qualify for membership under more than one membership class must be members for their primary business as determined by gross revenues.

Membership fees are due and payable on January 31st of each year. Renewal fees paid after March 31st may be subject to a $50 reinstatement fee. Call KHCA if you would like to make arrangements to pay your dues in installment payments.

STEP 3: CERTIFY INFORMATION

I certify that the information provided on this application is true and correct.

____
Print Name   Title (CEO/Administrator/CFO)

____
Authorized Signature Required

STEP 4: TOTAL 2018 DUES CALCULATION

❶	Full Agency Membership Total	$
❷	Associate Membership Total	$
❸	Networking Membership Total	$
	Total Applicable Dues	**$**

STEP 5: DUES PAYMENT

☐ **Invoice Requested**

☐ **Check Enclosed** # ____________

☐ **Credit Card**
(There will be a 2.5% fee if paying by credit card)

$ ________________ x 1.025 = $ ________________
Payment Amount   Total Due

CARD: ☐ VISA ☐ MasterCard ☐ American Express

____
Credit Card Number

____
Exp Date   CVV

____
Address of Cardholder

____

____

____
Print Name of Cardholder

____
Authorized Signature Required

NEW Remittance Address:

KENTUCKY HOME CARE ASSOCIATION

2333 ALEXANDRIA DRIVE

LEXINGTON, KY 40504