



Kentucky Home Care Association

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 NOT 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
	100,001 - 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**

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2 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

3 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	\$
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\$ _____

(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

1	Full Agency Membership Total	\$
2	Associate Membership Total	\$
3	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