MEMBERSHIP APPLICATION
2017 / 2018

AHHC of NC

Step 1 | Info

Agency Name: **Home Care/Hospice License No.:**

Parent Entity /Legal Owner *(if applicable):*

Key Contact/Voting Member
(one person designated to vote on behalf of agency): **Title:**

E-Mail Address: **Web Address:**

Physical Address: **Mailing Address:**

City: **State:** **Zip:**

Telephone: ( ) **Fax: ( )**

Facebook Page: **Twitter Account:**

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	☐ Not Applicable
Do you Provide Hospice Services?	☐ YES	☐ NO	☐ Not Applicable
Do you operate a Hospice Residential Facility?	☐ YES	☐ NO	
If yes, name and location of facility: _____			
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 Services?	☐ YES	☐ NO	
Is Your Agency a Provider of Medicaid PDN Services?	☐ YES	☐ NO	
Is Your Agency a Provider of Behavioral Health Services?	☐ YES	☐ NO	
Is Your Agency a Provider of Companion/Sitter Services?	☐ 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 Home Care Assoc. of America?	☐ YES	☐ NO	
Is Your Agency a Member of Carolinas Center for Hospice?	☐ YES	☐ NO	
Is Your Agency a Member of NC Assoc. LTC Facilities (NCALTCF)?	☐ YES	☐ NO	
Is Your Agency a Member of NCAMES?	☐ YES	☐ NO	
Is Your Agency a Member of NC Health Care Facilities Assoc (NCHCFA)	☐ YES	☐ NO	

Names & Email Addresses of Key Staff for the Above Office ONLY:

For additional Emails for this office, please attach a list with names and emails of all employees that should be on the listserv to receive AHHC's emails, see page 4 to include Emails for additional offices/locations.

1. **Administrator** Name: _____ E-Mail Address: _____
2. **CFO** Name: _____ E-Mail Address: _____
3. **Clinical Director** Name: _____ E-Mail Address: _____
4. **Billing Supervisor** Name: _____ E-Mail Address: _____
5. **Compliance Officer** Name: _____ E-Mail Address: _____
6. **QI Director** Name: _____ E-Mail Address: _____
7. **Nurse Aide Superv.** Name: _____ E-Mail Address: _____
8. **Marketing Director** Name: _____ E-Mail Address: _____
9. **Staff Development** Name: _____ E-Mail Address: _____
10. **IT** Name: _____ E-Mail Address: _____

STEP 2 | Number of Licensed Offices

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, alternative or bundled payment models, PACE, Division of Aging & Adult Services and private pay. Also include IPP, PCS, PDN and CAP services (include non-mental health CAP services such as CAP/DA, CAP Choice and CAP/C. CAP-I/DD 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, hospice routine home care services and Palliative Care, 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 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-I/DD, 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

Membership Dues Scale Gross Revenue	2017/2018 DUES
$ 1 – $ 250,000	$ 670
$ 251,000 – $ 500,000	$ 824
$ 500,001 – $ 1,500,000	$ 1,751
$ 1,500,001 – $ 2,500,000	$ 2,585
$ 2,500,001 – $ 3,500,000	$ 3,595
$ 3,500,001 – $ 4,500,000	$ 4,676
$ 4,500,001 – $ 5,500,000	$ 6,056
$ 5,500,001 – $10,000,000	$ 7,313
$ 10,000,001 – $15,000,000	$ 8,961
$ 15,000,001 – $20,000,000	$10,094
$ 20,000,001 – $25,000,000	$11,588
$ 25,000,001 – $30,000,000	$14,163
$ 30,000,001 – $35,000,000	$15,064
$ 35,000,001 – $40,000,000	$16,416
$ 40,000,001 – $45,000,000	$17,510
$ 45,000,001 – $50,000,000	$19,570
$ 50,000,001 – $55,000,000	$21,630

Membership Dues Scale Gross Revenue	2017/2018 DUES
$ 55,000,001 – $60,000,000	$23,690
$ 60,000,001 – $65,000,000	$25,750
$ 65,000,001 – $70,000,000	$26,420
$ 70,000,001 – $75,000,000	$28,377
$ 75,000,001 – $80,000,000	$30,334
$ 80,000,001 – $85,000,000	$32,291
$ 85,000,001 – $90,000,000	$34,248
$ 90,000,001 – $95,000,000	$36,205
$ 95,000,001 – $100,000,000	$38,162
$100,000,001 – $125,000,000	$40,556
$125,000,001 – $150,000,000	$49,569
$150,000,001 – $175,000,000	$50,213
$175,000,001 – $200,000,000	$57,938
$200,000,001 – $250,000,000	$69,525
$250,000,001 – $300,000,000	$84,975
$300,000,001 +	$92,700

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 to avoid a 3% surcharge. **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, NC 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.

Visa____ Mastercard _____ American Express_____ Discover_____

Account No.: **Expiration Date:** **Security Code:**

Address of Cardholder:

City: **State:** **Zip:**

Name: **Signature:**

ADDITIONAL OFFICE MEMBERSHIP FORM

(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 #:**

Branch Director: **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 #:**

Branch Director: **E-Mail Address:**

Mailing Address:

City: **State:** **Zip:**

Telephone: ( ) **Fax: ( )**

Is this licensed site Medicare-Certified? ☐ **YES** ☐ **NO**
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Agency Name: **Home Care/Hospice Licensure #:**

Branch Director: **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**

Name: _____ **E-Mail Address:** _____

Name: _____ **E-Mail Address:** _____

Name: _____ **E-Mail Address:** _____

Association for Home & Hospice Care of North Carolina
3101 Industrial Dr. Suite 204
Raleigh NC, 27609

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