MINNESOTA HOME CARE ASSOCIATION
WWW.MNHOMECARE.ORG
Voice OF HOMECARE
1711 West County Road B, Suite 211 S, St. Paul, MN 55113
651/635-0607 • Fax 651/635-0043 • Toll-Free 866/607-0607
www.mnhomecare.org

2014 PROVIDER APPLICATION

The information on this form is used, for the term of one year from January 1, 2014 through December 31, 2014, 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:
	State License #:
Business Mailing address/City/State/Zip: *(if different from physical address)*	County:
	MHCA Region:

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, that was 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 Due:** If adjusted revenue exceeds $2 million, then pay the flat rate of **$4,956**
- **Variable Due:** If adjusted revenue is more than $268,500 but less than $2 million, **multiply your adjusted revenue by .0024779946**, then round it to the nearest dollar, this will be your dues rate.
- **Minimum Due:** If adjusted revenue is less than $268,500, then pay the flat rate of **$665.**

New members are assessed an additional **$50 enrollment fee**. This fee also applies to Agencies who allow their membership to lapse (more than three months) and rejoin at a later date.

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 allocable to lobbying is 20%.

Prorated fees: New members who join after January 31 are prorated from the month joined to the end of the calendar year. To calculate, determine membership type; divide the dues rate by 12 months, then multiply it by the number of remaining months, including the month joined, through December.

VARIABLE DUES CALCULATION ONLY *(Rounded)*	
$ _____ X .0024779946	**= $**
MHCA FLAT RATE DUES	**= $**
NEW ENROLLMENT FEE/LATE FEE	**= $ 50.00**
TOTAL	**= $**

If you select bi-annual payment option there will be an additional $50 fee on your reminder invoice statement

Payment Option:	***Payment Method***
☐ Full Payment ☐ Bi-Annual	☐ Check ☐ Credit Card ☐ Bill Me

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)**

- ☐ Assisted Living
- ☐ County Public Health
- ☐ Home Care
- ☐ Hospice
- ☐ Palliative Care
- ☐ Personal Care Provider Organization
- ☐ Private Duty

Structure:

- ☐ Assisted Living
- ☐ County Public Health
- ☐ Hospital-based
- ☐ Nursing home-based
- ☐ Private Non-Profit
- ☐ Proprietary (for profit)

***Certification/Accreditation:**

- ☐ ACHC
- ☐ CHAP
- ☐ Home Management
- ☐ JCAHO
- ☐ Licensed in MN
- ☐ Medicare Certified (License #_____)
- ☐ Personal Care Provider Org. *(DHS registered)*

***Payment Methods Accepted:**

- ☐ 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
- ☐ TBI

***License Class:**

- ☐ Basic
  - ☐ Class B – Para-Professional Agency
  - ☐ Class C – Individual Para-Professional
  - ☐ Non Licensed Personal Care & Services Provider
- ☐ Comprehensive
  - ☐ Class A – Professional Home Care Agency
  - ☐ Class F – Assisted Living Home Care Program
  - ☐ Certificate of Home Management
  - ☐ Hospice Licensed

***Services Offered:**

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

Languages Spoken

- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ German
- ☐ Hindi
- ☐ Hmong
- ☐ Oromo
- ☐ Russian
- ☐ Somali
- ☐ Spanish

Agency Name:

THE DATA BELOW WILL BE USED *ONLY* 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 clients/average daily census *(for past fiscal year)*:	US Congressional District (if known):
Is agency exempt from sales tax?	☐ Yes ☐ No
Are you a member of the National Association for Home Care (NAHC)?	☐ 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/VOTING REPRESENTATIVE INFORMATION

Name:	
Alternate address if different from agency's address	
Direct Phone:	Alternate Phone:
E-mail Address:	

ALTERNATE REPRESENTATIVE INFORMATION *(Optional)*

Name:	
Alternate address if different from agency's address	
Direct Phone:	Alternate Phone:
E-mail Address:	