

PROVIDER MEMBERSHIP FORM



Agency: _____

Address: _____

City: _____ Zip: _____ State: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Contact Name: _____ Contact Title: _____

Contact Phone: _____ Contact Email: _____

Counties Served: _____

Number of Direct Employees, FTE's: _____ Actual No. of Employees: _____ No. of Contract Staff: _____

Agency Type: For Profit Non-Profit

Other Memberships: AFHHA ACHC NAHC NHPCO NPDA WAPDA

INSTRUCTIONS FOR COMPLETING THE DUES PORTION OF YOUR MEMBERSHIP APPLICATION:

1. Membership dues are based on revenue for the most recent completed fiscal year.
2. Pay before February 15, 2021 and you can take 5% discount off of your total dues amount.

Revenue:	Dues:	Revenue:	Dues:	Revenue:	Dues:	Revenue:	Dues:
Under 300,000	\$605	2,000,000 – 2,500,000	\$2,805	7,000,000 – 7,500,000	\$ 7,290	14,000,001 – 15,000,000	\$ 9,330
300,001 – 400,000	\$750	2,500,001 – 2,999,999	\$3,290	7,500,001 – 7,999,999	\$ 7,800	15,000,001 – 16,000,000	\$ 9,385
400,001 – 500,000	\$890	3,000,000 – 3,500,000	\$3,760	8,000,000 – 8,500,000	\$ 8,135	16,000,001 – 17,000,000	\$ 9,445
500,001 – 600,000	\$1,020	3,500,001 – 3,999,999	\$4,240	8,500,001 – 8,999,999	\$ 8,545	17,000,001 – 18,000,000	\$ 9,510
600,001 – 700,000	\$1,135	4,000,000 – 4,500,000	\$4,725	9,000,000 – 9,500,000	\$ 8,730	18,000,001 – 19,000,000	\$ 9,570
700,001 – 800,000	\$1,370	4,500,001 – 4,999,999	\$5,200	9,500,001 – 9,999,999	\$ 8,900	19,000,001 – 20,000,000	\$ 9,625
800,001 – 900,000	\$1,610	5,000,000 – 5,500,000	\$5,620	10,000,000 – 11,000,000	\$ 9,090	20,000,001 - and up	\$ 9,850
900,001 – 999,999	\$1,845	5,500,001 – 5,999,999	\$6,040	11,000,001 – 12,000,000	\$ 9,150		
1,000,000 – 1,500,000	\$2,090	6,000,000 – 6,500,000	\$6,460	12,000,001 – 13,000,000	\$ 9,205		
1,500,001 – 1,999,999	\$2,325	6,500,001 – 6,999,999	\$6,880	13,000,001 – 14,000,000	\$ 9,260		

3. Using the dues scale, 2021 dues _____

4. Apply 5% discount if before February 15, 2021, total: _____

5. Do you need an invoice emailed to you? _____

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PAYMENT METHOD:

Payment Amount: _____ Visa MasterCard Check Payable to HCAW

CARDHOLDER'S NAME:

Card Number: _____

Expiration Date: _____ Security Code: _____

Cardholder's Signature: _____

AFFILIATIONS:

Franchise HMO Hospital Nursing Home Official Private Public Voluntary

LICENSE TYPE:

Adult Day Health Home Health Pharmacy Home Care Hospice

CERTIFICATIONS:

CHAP Accreditation JCAHO Accreditation Medicare Home Health Certification

Medicare Hospice Certification Medicare Part "B" Provider NCQA

SERVICES PROVIDED:

- | | | |
|---|--|--|
| <input type="checkbox"/> Adaptive Equipment | <input type="checkbox"/> Adult Day Health | <input type="checkbox"/> Alzheimer's/Dementia Care |
| <input type="checkbox"/> Appointment Escorts | <input type="checkbox"/> Care Management | <input type="checkbox"/> Chores & Cleaning |
| <input type="checkbox"/> Companions | <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Home Modification |
| <input type="checkbox"/> Home Phototherapy | <input type="checkbox"/> Homemaking | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Incontinence Solutions | <input type="checkbox"/> Intravenous Therapy | <input type="checkbox"/> Live-In Aides |
| <input type="checkbox"/> Maternal & Child Health | <input type="checkbox"/> Medical Social Work | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Mental/Behavioral Health | <input type="checkbox"/> Nursing | <input type="checkbox"/> Nutritionist |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Ostomy Care | <input type="checkbox"/> Pain/Palliative Care |
| <input type="checkbox"/> Pediatric Nursing | <input type="checkbox"/> Personal Care/Home Health Aides | <input type="checkbox"/> Personal Emergency Response Systems |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Private Duty Nursing | <input type="checkbox"/> Psychiatric Nursing |
| <input type="checkbox"/> Respiratory Therapy | <input type="checkbox"/> Speech & Language Therapy | <input type="checkbox"/> Staffing |
| <input type="checkbox"/> Telehealth Monitoring | <input type="checkbox"/> Transportation | <input type="checkbox"/> Wound Care |

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TYPES OF PAYMENT ACCEPTED:

- | | | |
|---|--|---|
| <input type="checkbox"/> Amerigroup | <input type="checkbox"/> Community Health Plan of Washington | <input type="checkbox"/> Coordinated Care Corp |
| <input type="checkbox"/> Income-Based Sliding Scale Fee | <input type="checkbox"/> Long Term Care Insurance | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Medicare Advantage | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Molina Healthcare of Washington |
| <input type="checkbox"/> Private Pay | <input type="checkbox"/> State Assist | <input type="checkbox"/> United Healthcare Community Plan |
| <input type="checkbox"/> Veterans Administration | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other: _____ |

PROVIDER STAFF:

Please add any additional staff to have access to HCAW member benefits:

Employee #1	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All
Employee #2	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All
Employee #3	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All
Employee #4	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All
Employee #5	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All
Employee #6	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All

Employee #7	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All
Employee #8	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All
Employee #9	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All
Employee #10	
Name:	Title:
Email:	I would like to receive communications about: <input type="checkbox"/> Advocacy <input type="checkbox"/> Education <input type="checkbox"/> Member News <input type="checkbox"/> All

(Dues paid to the Home Care Association of Washington 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 restrictions imposed as a result of association lobbying activities. HCAW estimates that the nondeductible portion of your 2021 dues – the portion which is allocable to lobbying – is 36%. HCAW's tax ID# is 91-1102450.)

Return completed membership application to HCAW:
5727 Baker Way NW Suite 200 | Gig Harbor, WA 98332
P: 425-775-8120 | E: info@hcaw.org