

PROVIDER MEMBERSHIP FORM



Agency: _____

Address: _____

City: _____ Zip: _____ State: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Contact Name: _____ Contact Title: _____

Contact Phone: _____ Contact Email: _____

Counties Served: _____

Actual No. of Employees: _____ No. of Contract Staff: _____

Agency Type: For Profit Non-Profit

Other Memberships: NAHC NHPCO HCAOA WAHCA WSHPCO

INSTRUCTIONS FOR COMPLETING THE DUES PORTION OF YOUR MEMBERSHIP APPLICATION:

- Membership dues are based on revenue for the most recent completed fiscal year.
- Pay before February 15, 2023 and you can take 5% discount off of your total dues amount.

Revenue:	Dues:	Revenue:	Dues:
New Agency < 1 Year	\$299.00	4,000,000 - 4,999,999	\$4,961.25
Under 300,000	\$635.25	5,000,000 - 6,999,999	\$5,901.00
Out-of-State	\$750.00	N/A	N/A
300,000 - 499,999	\$787.50	7,000,000 - 7,999,999	\$7,654.50
500,000 - 999,999	\$1,312.50	18,000,000 - 9,999,999	\$8,610.00
1,000,000 - 1,999,999	\$2,194.50	10,000,000 - 14,999,999	\$9,240.00
2,000,000 - 2,999,999	\$2,945.25	15,000,000 - 24,999,999	\$9,870.00
3,000,000 - 3,999,999	\$3,948.00	< 25,000,000	\$13,125.00

- Using the dues scale, 2023 dues _____
- Apply 5% discount if before February 15, 2023, total: _____
- 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: _____

Cardholders Signature: _____

AFFILIATIONS:

Franchise HMO Hospital Nursing Home Official Private Public Voluntary

LICENSE TYPE:

Home Health Home Care Hospice

CERTIFICATIONS:

CHAP Accreditation JCAHO Accreditation Medicare Home Health Certification
Medicare Hospice Certification Medicare Part "B" Provider **NCQA**

SERVICES PROVIDED:

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

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TYPES OF PAYMENT ACCEPTED:

Amerigroup	Community Health Plan of Washington	Coordinated Care Corp
Income-Based Sliding Scale Fee	Long Term Care Insurance	Medicare
Medicare Advantage	Medicaid	Molina Healthcare of Washington
Private Pay	State Assist	United Healthcare Community Plan
Veterans Administration	Worker's Compensation	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	
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	
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 2023 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: carissa@aminc.org