Kansas Home Care Association
Membership Application
October 1, 2012 - September 30, 2013

For Office Use Only
District___/_____
N/R_____
Sector_____
G.R._____
Hard Copy_____

Step One: Company Information

Proof the following information on your agency. Please make changes as needed and fill in any blanks.

- ✓ State ID Provider Number: _____
- ✓ PTAN/Provider #: 17 - ___ ___ ___ ___ __
- ✓ KanCare/Medicaid#:_____
- ✓ Medicare Certified: _____
- ✓ Payer Sources Accepted:

____Medicare ____Insurance

____KanCare/Medicaid ____Private Pay

____Tri-Care ____HCBS

____VA ____Other State Programs Accepted

- ✓ Provider/Company Name: _____
- ✓ Mailing Address: _____
- ✓ Contact Person (Person Designated to Receive Mailings): _____
- ✓ Phone:_____
- ✓ Fax:_____
- ✓ E-Mail Address: _____
- ✓ **Other Contact Person**: _____
- ✓ **Phone:**_____
- ✓ **E-Mail Address:**_____
- ✓ Web Site Address *(a link will be placed on the KHCA website)*: _____
- ✓ County of Office Location: _____
- ✓ Counties Served: _____
- ✓ Type of Organization *(Choose the **ONE** sector that best represents your business – **FOR VOTING PURPOSES ONLY**)*:

_____ Institutional (Hospital or Nursing Home based)

_____ Not-for-Profit

_____ Proprietary (For-Profit)

_____ Official (Public Health Dept. based)

- ✓ Company Description (For Associate Members Only): _____

_____

_____

(Membership Categories Continued on Reverse Side) ➔

Step Two: Dues Schedule

Locate your membership category and check the corresponding dues rate.

Note: Provider entities with different licensure numbers must use separate application forms. Membership rights and benefits are non-transferable. They shall pertain only to the single licensed entity listed on this application. Misuse of association benefits may result in the loss of membership.

1. **In-Home Service Provider Membership:** Organizations whose primary business is the provision of health and/or support services which are delivered in the home. "Gross Revenue" includes total charges for all services delivered in the home. Please check the appropriate category.

Gross Revenue Per Year				Dues	Gross Revenue Per Year				Dues
0	-	$50,000	_____	$402	$750,001	-	$1,000,000	_____	$1013
$50,001	-	$150,000	_____	$522	$1,000,001	-	$1,500,000	_____	$1065
$150,001	-	$250,000	_____	$555	$1,500,001	-	$2,000,000	_____	$1280
$250,001	-	$500,000	_____	$660	$2,000,001	-	$10,000,000	_____	$1492
$500,001	-	$750,000	_____	$799	$10,000,001	-	Over	_____	$1967

2. **Associate Membership:** Official, regulatory, voluntary, and/or private organizations interested in the work of the association, but do not provide direct patient services in the home. _____ $410

3. **Individual Membership:** Persons interested in the promotion of home care in the state but would not be eligible for membership in another category or are not employees of another provider group. _____ $163

Note: Some agencies may deduct a portion of their membership dues as an "ordinary and necessary business expense" on federal income tax. *The IRS (Omnibus Reconciliation Act of 1993) prohibits you from deducting the portion of your membership dues, which are allocable to the lobbying activities of this organization. The Kansas Home Care Association reasonably estimates that 10% of your dues are allocable to lobbying expenditures in 2013; therefore 10% of your dues are not deductible in 2013. You should seek further information on these requirements from your attorney or tax advisor.*

Step Three: Branch Office Listing for Website

Please list all branch office locations (name, city, and phone) that you would like included in the KHCA on-line membership directory.

«Branch_Offices»

Step Four: Agency Information

Approximately how many patients do you serve on a monthly and yearly basis?

_____ Home Care _____Hospice

What percentage of your patients is?

_____Medicare _____Waiver _____Medicaid _____ Private Pay

How many staff members do you currently have in your agency?

_____Nurses _____Therapists _____Aides _____Other

Step Five: Sign and Submit Application with Payment

A. Signature Required

By this signature, I verify that the information provided on this application form is, to the best of my knowledge, correct. I understand that the membership benefits that we receive are only to be used by the company and state ID provider number listed in Step One and its employees. Furthermore, I understand that these benefits may not be transferred to another licensed agency or business, which does not hold membership in this association. Any misuse of membership rights and benefits may result in the termination of our membership. I am aware that information on contacting my company will be available for viewing by the public on the KHCA website. **Communication Consent: I understand that by providing my mailing address, email address, telephone number and fax number, I consent to receive communications, both commercial and non-commercial, via regular mail, email, telephone and/or fax sent by or on behalf of the Kansas Home Care Association (KHCA)**.

_____ _____

Administrator or contact person Date

B. Total Amount Due

Check payable to "KHCA" (2012-2013 Membership Dues from Step Two) **$**_____

If payment is not included, please indicate when a check will be forthcoming: _____

C. Return Application and Payment to:

Kansas Home Care Association
P.O. Box 750023 / Topeka, KS 66675

Questions? Contact Beth Harrison, KHCA Business Manager, at 785/246-4334 or bharrison@kshomecare.org