National Alliance for Care at Home

PROVIDER MEMBERSHIP APPLICATION

Organization Name: _____

Primary Location Address: _____

_____

City _____ State _____ Zip: _____

Country _____

Main Phone: _____ Main Fax: _____

Website: _____

CERTIFICATIONS: (enter number or update as needed where applicable)

Primary Home Care Med Cert ID#: _____ Primary Hospice Med Cert ID#: _____

PRIMARY CONTACT:

Primary Contact: _____ Primary Contact Title: _____

Primary Contact Phone: _____ Primary Contact Email: _____

NAME OF VOTING CONTACT: (if not primary contact)

Voting Contact: _____ Voting Contact Title: _____

Voting Contact Phone: _____ Voting Contact Email: _____

UPDATE YOUR ORGANIZATION'S OVERALL PROFILE WITH US:

Current Number of FTEs: _____

VOTING SECTION: (pick one)

- ◯ Home Health
- ☐ Hospice
- ◯ PD Home Care
- ◯ National Provider
- ◯ Integrated Health System Provider

PROVIDER TYPE: (check all that apply)

- ☐ Home Health
- ☐ Hospice
- ☐ Infusion
- ☐ Palliative
- ☐ Pediatrics
- ☐ PD Home Care

ENTITIY TYPE: (check all that apply)

- ☐ Institution-based
- ☐ Government-based
- ☐ Freestanding National
- ☐ Integrated Health System Provider
- ☐ For Profit
- ☐ Nonprofit
- ☐ Provider
- ☐ Health System Affiliated (affiliated with a non-home care entity)
- ☐ Rural
- ☐ Urban

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PROVIDER DUES CHART

Provider dues are tiered based on NPSR	Dues
0 – 299,999	$750
300,000 – 499,999	$950
500,000 – 999,999	$1,700
1,000,000 – 2,499,999	$2,700
2,500,000 – 4,999,999	$3,950
5,000,000 – 9,999,999	$5,450
10,000,000 – 14,999,999	$7,950
15,000,000 – 19,999,999	$11,450
20,000,000 – 24,999,999	$13,950
25,000,000 – 34,999,999	$17,950
35,000,000 – 49,999,999	$23,950
50,000,000 – 74,999,999	$31,450
75,000,000 – 99,999,999	$39,950
100,000,000 – 149,999,999	$49,950
150,000,000 – 174,999,999	$61,950
175,000,000 – 224,999,999	$74,950
225,000,000 – 249,999,999	$90,450
250,000,000 – 449,999,999	$108,950
450,000,000 – 599,999,999	$131,500
600,000,000 – 699,999,999	$159,500
700,000,000 – 899,999,999	$191,500
900,000,000 – 999,999,999	$231,500
1,000,000,000+	$263,500

*Net patient service revenue is reported based on the last financials completed. The NPSR is at net realizable amounts from patients, third party payors and others related to all care in the home service lines rendered by all locations.

4 PAYMENT OPTIONS:

1. **SAVE TIME AND MONEY RENEWING ONLINE**
   AllianceForCareAtHome.org
2. **MAIL:**
   ALLIANCE LOCKBOX
   PO Box 37558
   Baltimore, MD 21297-3558
3. **FAX#:**
   703-837-1233
4. **EMAIL:**
   membership@AllianceForCareAtHome.org

Please contact us at (800) 646-6460 or membership@AllianceForCareAtHome.org if you have any questions.

DUES CALCULATION:

Please use the chart to the left to determine your dues.*

DUES: $_____

OPTIONAL SUBSCRIPTIONS/SERVICES/HHFMA: (check to Select)

☐ **MSDSOnline Subscription** $_____

The annual fee for the first location is $55 and $30 for each additional location. If ordering subscriptions for more than one location, The Alliance will follow up with the member to identify the MSDSOnline contacts at each additional location.

A. Fee for First Location $_____

B. Additional locations # ____ x $30.00 + $_____

C. Total MSDSOnline Subscription (A+B=C) $_____

Confirm MSDSOnline Primary Location Contact (required)

Name: _____ Phone: _____

Email: _____

☐ **Journal of Pain and Symptom Management** $_____

One-year subscription $160 (12 issues)

☐ Add **Home Care and Hospice Financial Managers Association (HHFMA)** $150 per individual $_____

Attach list of Names, Titles, and Emails of those you wish to join HHFMA.

SELECT IF PAYING IN FULL OR IN INSTALLMENTS (please select one)

☐ **Grand Total - Payment in full** **$_____**

◯ **Semi-annual Payments** **$_____**

First payment is due with this application then six months from start of membership term second payment is due. (Example: if paying for Jan 1, your second payment is due July 1)

◯ **Quarterly Payments:** **$_____**

First payment is due with this application then pay the next 3 installments in 3 month increments after start of membership term (Example: if the membership term starts Jan 1, the second is due April 1, third payment July 1, last payment October 1)

NOTE: If paying in installments, the first installment must include ½ or ¼ dues plus fees for additional subscriptions, services, and HHFMA. If paying by credit card you have the option to pay by autopay on your installment due dates.

☐ **Check box to agree to have card charged via autopay on due dates.**

PAYMENT TYPE USED:

☐ **CHECK ENCLOSED** Check #:_____

◯ **ACH –** TRUIST Bank, Routing/Transit #021052053 Account #: 22698819

◯ **CREDIT CARD**

◯ VISA ◯ MASTERCARD ◯ AMERICAN EXPRESS ◯ DISCOVER

_____
Credit Card Number

_____
Expiration Date Billing Zip Code CVV# (found on back of the card)

_____
Print name as it appears on card Signature of Cardholder

NOTE: Please include all completed forms when sending payment or when submitting an ACH payment. Incomplete applications result in processing delays. Thank you for your membership in the Alliance!

Association dues payments, to the Alliance or otherwise, are not tax deductible as charitable contributions, Sections 501(c)5 and (c)6. The Internal Revenue Code limits the amount of business expense deductions for dues paid to an association that engages in lobbying activities even if dues are not used for lobbying; the amount excluded is currently 23% based on IRS criteria. EIN - 84-0617736.

Alliance membership dues are non-refundable.

Please consider making a charitable donation to the National Alliance for Care at Home Foundation: AllianceForCareAtHome.org/foundation.org

National Alliance for Care at Home

ALLIANCE PROVIDER MEMBER ATTESTATION

The National Alliance for Care at Home ("the Alliance") is committed to promoting the highest levels of quality, integrity, and ethics in healthcare delivery and business practice. The Alliance Board of Directors may, at its sole discretion, deny, revoke, or suspend the membership of any individual or entity at any time.

To be admitted to and maintain membership in the Alliance, a provider must attest to the following (or identify those which are not applicable):

1. Our organization has documented policies and procedures related to quality improvement, regulatory compliance, and informed consent. We have at least one designated point person for quality monitoring and regulatory compliance, and we ensure that all staff receive annual training on regulatory and compliance matters.

   ◯ Yes ◯ No ◯ Not Applicable (describe why below)

2. Our organization regularly checks the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) to ensure that employees, contractors, volunteers, and referring or attending physicians are not excluded from participation in federal healthcare programs.

   ◯ Yes ◯ No ◯ Not Applicable (describe why below)

3. All Medicare-certified home health agencies and hospices associated with our organization regularly submit data to the Medicare Quality Reporting Program and participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

   ◯ Yes ◯ No ◯ Have a Reasonable Exception (describe why below)

   ☐ Not Applicable / Not a Medicare Home Health or Hospice Provider

PERSON COMPLETING ATTESTATION:

Name: _____

Title: _____

Organization: _____

Phone: _____ Email: _____