



## Provider Membership Application

### I. GENERAL INFORMATION

Legal agency name	
Mailing address	
Branch addresses <i>Please attach additional sheet if necessary</i>	
Phone	
Toll-free	
Administrative fax	
Referral fax	
Website address	
Agency email	

### II. KEY PERSONNEL

Please review or otherwise provide the names of individuals most appropriate to receive special interest mailings. In addition, please place an asterisk (\*) next to the name of the individual(s) designated to receive all major notices.

	<i>Name</i>	<i>Email Address</i>
Executive Director/CEO		
Financial Manager		
Clinical Director		
Home Health Aide Supervisor		
Marketing Coordinator		
Rehab Therapy Coordinator		
Hospice Coordinator		
CQI Coordinator		
Social Work Coordinator		
Education Coordinator		
Human Resources Manager		
IT/IS Manager		
Private Duty		
Wound Care		
Emergency Preparedness Program		

### Maintain important agency information online and in real-time!

Once your membership application is approved, your agency will be added to our online provider database. This allows visitors to our website to "find a provider" in each NH town and to view detailed information about the services your agency offers, the payment sources you accept, etc. Members also can post job openings on the Home Care Association website at no charge.

We will be assigning you a login and password that allows you access to our website's administrative "back end". Then we'll walk you through the initial set-up, and explain how to post jobs online. After the initial set-up, you will be expected to keep your profile up to date to ensure that visitors to our website have the most accurate information available. This same login and password will also give you access to the members-only articles and sections of our website, so you may wish to share the access codes with other staff members.

We strongly encourage members to identify a point person to review your online profile periodically and update information throughout the year.

### III. AGENCY INFORMATION

Please provide the following information as directed.

**A. Type of Agency (Mark (x) all that apply)**

- Medicare Certified Home Health Care Agency
- State Licensed Home Health Care Provider (809)
- State Licensed Home Care Service Provider (822)
- Homemaker/Home Health Aide Agency
- Home Infusion Company
- Medicare Certified Hospice Agency
- Other (Describe) \_\_\_\_\_

**Affiliations: (Mark (x) all that apply)**

- JCAHO
- CHAP
- NAHC
- VNAA

**B. Name of Computer Software System Manufacturer (for billing, clinical functions)**

\_\_\_\_\_

**C. Total Agency Board, Staff and Volunteers(12-month estimate)**

	Current estimate
# of Board members	
# of employees (i.e., staff, per diem, contract)	
# of volunteers (excluding Board)	

**D. Total Agency Clients (12-month estimate)** (Detail payor source if possible)

	Medicare	Medicaid	Other	Total
# of unduplicated clients served				
# of home care visits (all services combined)				
# of miles traveled by staff				

### IV. OTHER REQUIREMENTS

This section must be completed and signed by the Agency's executive director or chief executive officer.

**A. Medicare Fraud/Abuse Certification**

Have you or your organization been convicted of or pleaded guilty to charges of Medicaid or Medicare fraud and/or abuse or other illegal activity during the past two years?  Yes  No

If yes, please describe the situation and present status on a separate sheet of paper, and include it with your returned application.

**B. Membership Application Attachments. The following information must be included with your renewal application.**

- Complete and accurate Application signed by the Agency's CEO.
- Completed Dues Computation Form signed by the Agency's CEO.
- Current fiscal year audited financial statements for the agency, excluding agencies submitting dues at the \$10,500 maximum level.

**C. Certification of Application**

*I hereby signify that I have read the current HCANH Membership and Dues Policies including the Association's Code of Ethics, as adopted by the HCANH Board of Directors, and agree to abide by these policies. I further certify that the information included in this application is complete and accurate to the best of my knowledge.*

\_\_\_\_\_  
Executive Director/CEO Signature

\_\_\_\_\_  
Date