MEMBERSHIP APPLICATION 2024 / 2025

Step 1 | Info

Agency Name: ______________________________

Parent Entity /Legal Owner *(if applicable)*: ______________________________

Key Contact/Voting Member
***(one person designated to vote on behalf of agency)*:** ______________________________ **Title:** ______________

E-Mail Address: ______________________________ **Web Address:** ______________

Mailing Address: ______________________________

City: ______________________________ **State:** ________ **Zip:** ________

Telephone: (   ) ______________________________ **Fax: (   )** ______________

Facebook Page: ______________________________ **Twitter Account:** ______________

Ownership: ☐ Public ☐ Private Non-Profit ☐ Private For-Profit ☐ Hospital-Based/Public
☐ Hospital-Based/ Private Non-Profit ☐ Hospital-Based/ Private For-Profit

Do you provide Medicare Certified Home Health Services? ☐ YES ☐ NO

Do you provide Hospice Services? ☐ YES ☐ NO

Do you provide Medicaid Waiver Personal Care Services ☐ YES ☐ NO

Do you provide Private Duty Home Care? ☐ YES ☐ NO

Is Your Agency Accredited? ☐ YES ☐ NO

If yes, by whom are you accredited? ______________________________

How many additional sites are operated under your parent entity in SC? __________
*****If you operate more than one site in SC, please complete the attached "Additional Office Membership" Form*****

Names & Email Addresses of Key Staff for the Above Office ONLY:

For additional Emails for this office, please attach a list with names and emails of all employees that should be on the listserv to receive SCHCHA emails. See page 4 to include Emails for additional offices/locations.

1. **Administrator** **Name:** ______________________ **E-Mail Address:** ______________________
2. **CFO** **Name:** ______________________ **E-Mail Address:** ______________________
3. **Clinical Director** **Name:** ______________________ **E-Mail Address:** ______________________
4. **Billing Supervisor** **Name:** ______________________ **E-Mail Address:** ______________________
5. **Compliance Officer** **Name:** ______________________ **E-Mail Address:** ______________________
6. **QI Director** **Name:** ______________________ **E-Mail Address:** ______________________
7. **Nurse Aide Superv.** **Name:** ______________________ **E-Mail Address:** ______________________
8. **Marketing Director** **Name:** ______________________ **E-Mail Address:** ______________________
9. **Staff Development** **Name:** ______________________ **E-Mail Address:** ______________________
10. **IT** **Name:** ______________________ **E-Mail Address:** ______________________

STEP 2 | Membership Dues Calculation

Dues are based upon a parent entity's gross revenue for the most recent fiscal year from all offices in South Carolina. For the purpose of dues calculation, gross revenue **includes revenue from Certified Medicare / Medicaid Home Health services such as intermittent home care visits (nursing, aide, PT, OT, SLP, MSW, nutrition, and supplies); Hospice services, Medicaid Waiver Personal Care Services and Private Duty Home Care**.
Revenue is regardless of payor source and includes Medicare, Medicaid, insurance and private pay.
(When calculating Gross Revenue, you may exclude the following items: contractual adjustments; bad debts; investment income; charitable donations, funds raised through special events and philanthropic dollars.)

Revenue received from Medicare / Medicaid Certified Home Health: $____________________

Revenue received from Hospice Services: $____________________

Revenue received from Medicaid Waiver Personal Care Services: $____________________

Revenue received from Private Duty Home Care: $____________________

Total Revenue for Dues Calculation: $____________________

Gross Revenue	ANNUAL DUES
$ 1 – $ 500,000	$ 2,008
$ 500,001 – $ 1,500,000	$ 2,865
$ 1,500,001 – $ 2,500,000	$ 3,870
$ 2,500,001 – $ 3,500,000	$ 5,302
$ 3,500,001 – $ 8,500,000	$ 7,162
$ 8,500,001 – $13,500,000	$ 8,596
$ 13,500,001 – $18,500,000	$10,044
$ 18,500,001 - $25,000,000	$12,773
$ 25,000,001 – $35,000,000	$15,874
$ 35,000,001 - $50,000,000	$ 19,257
$ 50,000,001 +	$ 23,067

For The Person Authorized To Verify Net Revenue:

Name: ____________________ Title: ____________________
(please print)

Signature: ____________________ Telephone: (   ) ____________________
(include area code)

STEP 3 | Payment

All membership dues must be paid in full. Dues may be paid by check or credit card. Make checks payable to: South Carolina Home Care & Hospice Association.

☐ I have enclosed a check in the amount of $ ________________

☐ Please charge my credit card in the amount of $ ____________
☐ Visa ☐ MasterCard

Account No.: **Expiration Date:** **Sec. Code:**

Address of Cardholder:

City: **State:** **Zip:**

Name: **Signature:**
(as it appears on credit card)

IMPORTANT NOTICE: All reported membership information is confidential. Dues payments to the SC Home Care & Hospice Association are not deductible as a charitable contribution for federal income tax purposes. However, dues payments may be deductible as ordinary and necessary business expense, subject to exclusion for lobbying activity. Because a portion of your dues is used for lobbying by the SCHCHA, 30% of your dues are not deductible for income tax purposes.

If you have any questions about dues payments, please call the SCHCHA office at 919-848-3450 or e-mail Judy Penn, COO, judy@ahhcnc.org. Please complete this renewal form and return with dues payment to the SCHCHA, c/o AHHC, 3101 Industrial Drive, Suite 204, Raleigh, NC, 27609.

VENDOR INFORMATION (Optional)

SCHCHA is trying to grow our Affiliate Membership category by recruiting vendors of products and services that work with our members in South Carolina. Would you be willing to share the contact info from some of your vendors? If so, please complete the info below. Many thanks for your help!

Company Name: ____

Contact Name: ____

Phone: ____

Email Address: ____

Company Name: ____

Contact Name: ____

Phone: ____

Email Address: ____

ADDITIONAL OFFICE MEMBERSHIP

(Make copies of this form to list additional offices, if necessary)

Please Complete This Form If You Have More Than One Office Located in South Carolina. This Will Ensure That Each Office Receives All Member Benefits.

Agency Name: ______________________________

Administrator: ______________ **E-Mail Address:** ______________

Mailing Address: ______________________________

City: ______________ **State:** ______ **Zip:** ______

Telephone: (   ) ______________ **Fax: (   )** ______________

Additional Staff E-Mails for this location:

Name: ______________ **E-Mail Address:** ______________

Name: ______________ **E-Mail Address:** ______________

Name: ______________ **E-Mail Address:** ______________

Agency Name: ______________________________

Administrator: ______________ **E-Mail Address:** ______________

Mailing Address: ______________________________

City: ______________ **State:** ______ **Zip:** ______

Telephone: (   ) ______________ **Fax: (   )** ______________

Additional Staff E-Mails for this location:

Name: ______________ **E-Mail Address:** ______________

Name: ______________ **E-Mail Address:** ______________

Name: ______________ **E-Mail Address:** ______________

Agency Name: ______________________________

Administrator: ______________ **E-Mail Address:** ______________

Mailing Address: ______________________________

City: ______________ **State:** ______ **Zip:** ______

Telephone: (   ) ______________ **Fax: (   )** ______________

Additional Staff E-Mails for this location:

Name: ______________ **E-Mail Address:** ______________

Name: ______________ **E-Mail Address:** ______________

Name: ______________ **E-Mail Address:** ______________

South Carolina Home Care & Hospice Association
3101 Industrial Dr. Suite 204
Raleigh NC, 27609

P 919-848-3450 | F 919-848-2355

E-Mail: info@ahhcnc.org

Website: schcha.org