



MEMBERSHIP APPLICATION 2021 / 2022

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	\$ 1,786
\$ 500,001 – \$ 1,500,000	\$ 2,547
\$ 1,500,001 – \$ 2,500,000	\$ 3,440
\$ 2,500,001 – \$ 3,500,000	\$ 4,713
\$ 3,500,001 – \$ 8,500,000	\$ 6,367
\$ 8,500,001 – \$13,500,000	\$ 7,641
\$ 13,500,001 – \$18,500,000	\$ 8,930
\$ 18,500,001 - \$25,000,000	\$11,356
\$ 25,000,001 – \$35,000,000	\$14,112
\$ 35,000,001 - \$50,000,000	\$ 17,199
\$ 50,000,001 +	\$ 20,507

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

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E-Mail: info@ahhenc.org

Website:
schcha.org