Provider Membership Application

Oregon Association for Home Care
1249 Commercial St. SE ● Salem, OR 97302
Phone: (503) 364-2733 ● Fax: (877) 458-8348 ● www.oahc.org

Due January 31, 2020

Provider Members are Home Health, Hospice, or In Home Service provider agencies that deliver home care and supportive services in the home.

Step 1: Contact Information (please print clearly)

The information provided will be listed in the printed membership directory and displayed in the online Find A Provider search.

Agency / Company Name: _____

Primary Contact: _____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Step 2: Annual Dues Calculation

Provider dues are calculated based on total gross revenues from the previous fiscal year. Do not combine revenues from locations with a different provider number. Different provider numbers with the same type of service(s) require a separate provider membership.

Total Gross Revenue

Please provide the following information for each type of service your agency provides to calculate your total gross revenues. Provider Number and Revenue are required.

☐ Home Health: Provider Number: _____ Total Revenue: $ _____

☐ Hospice: Provider Number: _____ Total Revenue: $ _____

☐ In-Home: Provider Number: _____ Total Revenue: $ _____

Total Gross Revenues: $ _____

Provider Level	Total Gross Revenues	Annual Dues
1	0-499,999	$695.12
2	500,000-999,999	$1,447.21
3	1,000,000-1,499,999	$2,256.65
4	1,500,000-1,999,999	$3,128.20
5	2,000,000-2,499,999	$3,520.11
6	2,500,000-2,999,999	$3,937.67
7	3,000,000-3,499,999	$4,380.68
8	3,500,000-3,999,999	$4,850.14
9	4,000,000-4,499,999	$5,345.66
10	4,500,000-4,999,999	$5,871.04
11	5,000,000-7,499,999	$6,425.99
12	7,500,000- Up	$7,011.60

Using the total gross revenues calculated above, find the appropriate dues level from the table on the left:

2020 Dues: $ _____

***Corporate Discount** – Any corporate member with three (3) or more provider agencies and those agencies have applied for membership in 2020, may qualify for the corporate discount. Gross revenues up to $5 million will receive a 20% discount. Gross revenues greater than $5 million will receive a 10% discount. If you qualify for the corporate discount, please fill out the form on the next page.

Your association dues are not deductible as a charitable contribution for federal income tax purposes. The 1994 Federal Revenue Reconciliation Act requires that only dues payments not associated with lobbying/advocacy issued in 2020 may only deduct 90% as an ordinary and necessary business expense. For specific guidelines members are directed to consult their accountant.

Corporate Discount Calculations:

Please list the agencies that qualify you for the corporate discount.

1: Agency Name: _____ Primary Contact: _____ Location: _____
2: Agency Name: _____ Primary Contact: _____ Location: _____
3: Agency Name: _____ Primary Contact: _____ Location: _____

☐Gross Revenues less than 5 million: Dues before discount $_____ x .80 = **2020 Dues $ _____**

☐Gross Revenues greater than 5 million: Dues before discount $_____ x .90 = **2020 Dues $ _____**

Additional Branch Listings - $135 per listing

If you would like to have any of your branch locations listed in the annual printed membership directory, please provide the following information. Do not include locations that have different provider numbers than the agency applying for membership. Gross revenues from branch locations must be included in total revenues calculated on this application.

Listing 1

Agency / Company Name: _____
Primary Contact: _____ Email: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Listing 2

Agency / Company Name: _____
Primary Contact: _____ Email: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Listing 3

Agency / Company Name: _____
Primary Contact: _____ Email: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Step 3: Dues Payment

Please note that in order for your membership application to be processed, all contact information, dues calculations and demographic information must be provided.

Total Dues Amount $ _____
(Please include additional site listings in total, if applicable)

☐ Check
Make checks payable to OAHC and mail to: OAHC, 1249 Commercial St. SE, Salem, OR 97302.

For Credit Card Payments:

☐ Visa ☐ MasterCard

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV: _____

For faster processing, fax your entire application to (877) 458-8348 or email to admin@oahc.org

For payments over the phone, please contact Brandy Sweet at (503) 364-2733 or bsweet@oahc.org

Step 4: Agency Demographic Survey

All information is required. Mark all that apply.

1. Is your agency: ☐ Hospital Based ☐ Free Standing ☐ For Profit ☐ Not for Profit

2. Total # of Employees: _____ **3. Average Daily Census:** _____

4. Total Miles Driven (most recent FY)**:** _____ **5. Total # of Visits** (most recent FY) **:** _____

6. Is your agency Medicare Certified? ☐ Yes ☐ No **7. Licensed Only?** ☐ Yes ☐ No

8. Yes, I provide services to clients in another state. Please list state(s): _____

_____

9. Do you belong to: ☐ NAHC (National Association for Home Care & Hospice) ☐ OHA (Oregon Hospice Association)
☐ Other associations (Please list):_____

10. What counties in Oregon do you serve? _____

_____

11. What cities in Oregon do you serve? _____

_____

12. Certification / Accreditation: ☐ Medicare Home Health ☐ Medicare Hospice ☐ JCAHO ☐ CHAP ☐ OHA
☐ ACHC ☐ Other _____

13. Home Health Services: ☐ Medical Social Worker ☐ Physical Therapy ☐ Occupational Therapy
☐ Speech Therapy ☐ Skilled Nursing ☐ Home Health Aide

14. In-Home Services: ☐ CNA/HHA ☐ LPN ☐ RN ☐ Companion ☐ Live-In ☐ Skilled Nursing
☐ Licensed by the State of Oregon ☐ Other _____

15. Hospice Services: ☐ Bereavement Program ☐ Hospice Aide ☐ Medical Social Worker ☐ Occupational Therapy
☐ Pastoral Care ☐ Physical Therapy ☐ Respite Care ☐ Skilled Nursing
☐ Speech Therapy ☐ Volunteers ☐ IV Therapy Providers ☐ HME / Respite Provider
☐ Infusion ☐ Prescription ☐ Other _____

16. Palliative Care: Please provide the name of the associations you're connected with_____

_____

17. Infusion Services: ☐ Infusion ☐ Prescription

See next page for adding contacts to the OAHC database and Special Offers.

Step 5: Update Your Agency's Contact List

Add employees to our database to receive all mailings, access to member's only sections of the OAHC website, and announcements on OAHC educational offerings.

Employee 1:
Name: _____ Title: _____
Email: _____ ☐ Add to Listserv

Employee 2:
Name: _____ Title: _____
Email: _____ ☐ Add to Listserv

Employee 3:
Name: _____ Title: _____
Email: _____ ☐ Add to Listserv

Employee 4:
Name: _____ Title: _____
Email: _____ ☐ Add to Listserv

Employee 5:
Name: _____ Title: _____
Email: _____ ☐ Add to Listserv

Special Offers!

1st Time Provider Member?

Agencies who have not previously been OAHC members may have dues prorated on a quarterly basis for the first year only. Minimum dues are $695.12. **New members** receive a **complimentary attendance** to the **2020 OAHC Annual Conference** (a $400 value). Details will be included with your new member welcome packet.

Annual Conference Registration Discount

Register 3 or more for the 2020 Annual Conference and receive $50 offer per person. Use promo code: **2020DISCOUNT** during the online registration process. **Offer expires December 31, 2019.**
(applies only to full conference registration)

Refer An Agency!

Get **10% off** your 2020 dues by recruiting a non-member agency to join OAHC. If a new agency uses your agency's name as a reference, then OAHC will refund your agency 10% off your total dues.

Were you referred to OAHC by another agency? Please list the name(s) of the agency or agencies who referred you to OAHC:_____