



## 2010 Home Care Dues Structure and Calculation

Agency Name: \_\_\_\_\_ Date: \_\_\_\_\_

### 2010 Dues Calculation: No increase in dues for 2010!

Dues calculation – use latest 2008 Gross revenue information: \*\* Gross Revenue includes all revenue generated in Ohio for all locations included in this application. Include all revenue generated from in-home care. **Exclude** hospice and/or other non-related business costs. Hospice Organization membership is calculated separately.

All dues amounts above \$1,000,000 should be calculated at a multiplier of .00075 until you get to the \$6.5 million mark.

Revenue **	Dues
Up to \$999,999	Base \$500
\$1m to \$6.5m	X .00075
>\$6.5m to \$10m	\$5,000.00
>\$10m to \$15m	\$5,300.00
>\$15m to \$25m	\$5,700.00
>\$25m to \$35m	\$6,200.00
>\$35m	\$7,000.00

#### **Membership Discount Program**

*(see below for an explanation of the discount program available)*

*This form **MUST** accompany your membership application in order to receive the discounted rate.*

<b>Base Dues Amount</b>	\$ _____	
<b>Less Program Discount of 15%</b> <i>(Program must be indicated above)</i>	( _____ )	
<b>Record your Total Dues Amount</b>		\$ _____

*Record this amount on the front page of your Membership Application*

### **Membership Discount Program**

In an effort to assist programs with rising costs we are facing in today's economy, OHPCO and OHCO are pleased to offer the following discount program:

<b>JOINT</b>
<b><i>For Home Care &amp; Hospice with a corporate relationship</i></b>
If both Home Care and Hospice join the organization, receive a <b>15%</b> discount off your total dues.

**NOTE: Dues must be paid in full to receive discount!**

**If you need assistance with payment arrangements, please contact Jennifer Taylor (614) 763-0036!**

**JOIN TODAY!**

Agency Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Director \_\_\_\_\_  
 Director Email \_\_\_\_\_  
 Key Contact (Name/Title) \_\_\_\_\_  
 Key Contact Email \_\_\_\_\_  
 Clinical Director (Name) \_\_\_\_\_  
 Clinical Director Email \_\_\_\_\_  
 Finance/Billing Supervisor (Name) \_\_\_\_\_  
 Finance/Billing Supervisor Email \_\_\_\_\_  
 Case Manager (Name) \_\_\_\_\_  
 Case Manager Email \_\_\_\_\_  
 Website Address \_\_\_\_\_  
 County of Primary Location \_\_\_\_\_

Total Number of Patients **for all sites**, served in most recent year of full data: \_\_\_\_\_

**Complete the following information for the MAIN SITE ONLY:**  
 (see Alternative Site Sheet to complete information for additional locations)

\*Medicare Federal ID # \_\_\_\_\_ \*National Provider ID # \_\_\_\_\_

\*What percentage of your business is:

Medicare _____ %	Medicaid _____ %	Waiver _____ %	Private Ins. _____ %	Charity _____ %	Other _____ %
Passport/Choices _____ %		MR/DD _____ %		I/O Waiver _____ %	




DISCIPLINES: (circle all that apply) SN PT OT ST AIDE MSW  
 Services Provided: (circle all that apply) Private Duty RN Personal Care Services Independent Living Aide Maternal/Child Health Emergency Response  
 Chore Services Hospice Pediatrics Transportation Respite  
 Type of Accreditation:  JCAHO  CHAP  ACHC Date of last Visit \_\_\_\_\_  
 Have you received Deemed Status Accreditation?  Yes  No  
 Counties Served: \_\_\_\_\_

**NOTE: OHCO & OHPCO do not pro-rate annual dues.**  
**Applications are due no later than January 31, 2010. All dues are for calendar year Jan-Dec.**

See Dues Structure and Calculation instructions attached.

Mail Membership Application with payment to:  
**Ohio Home Care Organization**  
 555 Metro Place North, Suite 650  
 Dublin, Ohio 43017

For any questions regarding dues and/or payment concerns,  
 please contact Jennifer at OHCO.

<b>Method of Payment:</b>		<b>Credit Card Payments:</b>		  
<input type="checkbox"/> Check Enclosed	<input type="checkbox"/> Invoice	<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	
Check Number: _____		Credit Card Number: _____	Exp. Date: ____/____ CV Code: _____	
Please make check payable to:		Name as appears on Card: _____		
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <b>Amount Due:</b>                  \$ _____             </div>		Card Mailing Address: _____		
		City & Zip Code: _____		
		Authorized Signature: _____		

Main Site Name: \_\_\_\_\_

List each Alternative Delivery Site location separately.

Please complete ALL information requested in order to be listed on the "Find a Provider" section of our website.

**Complete the following information for THIS ALTERNATIVE DELIVERY SITE ONLY:**

Agency Name \_\_\_\_\_ (Alternative Delivery Site # \_\_\_\_ of \_\_\_\_)  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Director \_\_\_\_\_  
 Director Email \_\_\_\_\_  
 Key Contact (Name)Title \_\_\_\_\_  
 Key Contact Email \_\_\_\_\_  
 Website Address \_\_\_\_\_  
 County Home \_\_\_\_\_

Medicare Federal ID # \_\_\_\_\_ National Provider ID # \_\_\_\_\_

\*What percentage of your business is:

Medicare _____%	Medicaid _____%	Waiver _____%	Private Ins. _____%	Charity _____%	Other _____%
Passport/Choices _____%		MR/DD _____%		I/O Waiver _____%	

DISCIPLINES: (circle all that apply) SN PT OT ST AIDE MSW

Services Provided: (circle all that apply)  
 Private Duty RN Personal Care Services Independent Living Aide Maternal/Child Health Emergency Response  
 Chore Services Hospice Pediatrics Transportation Respite

Type of Accreditation:  JCAHO  CHAP  ACHC Date of last Visit \_\_\_\_\_

Have you received Deemed Status Accreditation?  Yes  No

Counties Served: \_\_\_\_\_

**Complete the following information for THIS ALTERNATIVE DELIVERY SITE ONLY:**

Agency Name \_\_\_\_\_ (Alternative Delivery Site # \_\_\_\_ of \_\_\_\_)  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Director \_\_\_\_\_  
 Director Email \_\_\_\_\_  
 Key Contact (Name/Title) \_\_\_\_\_  
 Key Contact Email \_\_\_\_\_  
 Website Address \_\_\_\_\_  
 County Home \_\_\_\_\_

Medicare Federal ID # \_\_\_\_\_ National Provider ID # \_\_\_\_\_

\*What percentage of your business is:

Medicare _____%	Medicaid _____%	Waiver _____%	Private Ins. _____%	Charity _____%	Other _____%
Passport/Choices _____%		MR/DD _____%		I/O Waiver _____%	

DISCIPLINES: (circle all that apply) SN PT OT ST AIDE MSW

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Have you received Deemed Status Accreditation?  Yes  No

Counties Served: \_\_\_\_\_