

Provider Member Application

Membership Period: July 1, 2024 to June 30, 2025

The Missouri Alliance for Home Care, representing the home care industry in the state of Missouri, provides information, education, advocacy and promotion of the home care industry and its members.

Membership is based on the combination of **Sites ①** and **Programs ②**.

Enter the information below **EXACTLY** as the company should be listed with MAHC. This is what consumers will see on the "Find a Provider" Section of the website: www.homecaremissouri.org

① **Site Information:** (A "site" is a physical location of your company) All sites are considered members. Please complete a copy of this side of the application for **each site** and designate one the Main Site. (Photocopy this page as necessary)

- This is the *Only* Site **OR** Multiple Sites
 This is the Main Site
 This is *not* the Main Site

② **Programs Provided:** (A program is a type of Home Care Service provided by your company) More than one program marked is considered Multiple Programs. **NOTE: All services provided/offered MUST be included in your membership. Agencies cannot elect to pay for only one service if multiple are provided/offered. Policy non-compliance will result in follow-up communication.**

- Home Health Hospice In-Home Services/DSDS Consumer-Directed Services/DSDS Private Duty/Private Pay
 Private Duty Nursing/Medicaid Home Med. Equipment Infusion Therapy Adult Day Services Staffing
 Other _____

Company Information:

Company _____
Address (this site) _____
City _____ State _____ Zip _____ County _____
Phone _____ Fax _____
Website _____ Company Email _____
Contact Person _____ Email _____
Medicare Provider Number (Home Health Only) _____

Company Demographics:

Operational Structure: (check all that apply)

- Freestanding Freestanding/Franchise
 Government Based Hospital Based
 Nursing Facility Based Hospital Affiliated
 Not-For-Profit Proprietary
 Tax Exempt (Please attach letter of tax exemption)

Affiliations/Accreditations: (check all that apply)

- Accredited Organization MCHS Member
 MHPCA Member MoADSA Member
 NAHC Member VNAA Member
 HCAOA Leading Age
 MALA MHC

Ownership Control: (check one)

- Voluntary Non-Profit—Church Voluntary Non-Profit Other
 Proprietary Sole Proprietor Proprietary Partnership
 Proprietary Corporation Private, Non-Profit
 Governmental, City/County Other _____

Counties Served: List all counties that THIS SITE serves in the box. Identify non-MO counties with state name. Attach another page if needed. List counties served by this site only.

2024—2025 MAHC Provider Member Dues

① **Sites:** One Multiple Sites

② **Programs:** One Multiple Programs

*NOTE: All services provided/offered **MUST** be included in your membership. Agencies cannot elect to pay for only one service if multiple are provided/offered. Policy non-compliance will result in follow-up communication.*

③ **Calculation of Dues:** Determine the Net Operating Revenue for the ALL programs and sites you listed. “Net Operating Revenue” includes the most recent fiscal full year’s revenues, excluding disallowances, contractual adjustments and non-operating revenues such as gifts, bequests, and donations.

Net Operating Revenue for All Programs and Sites listed is: \$ _____

Provider Category		Net Operating Revenue					
① Site	② Program	\$0 - \$999,999	\$1 - \$4,999,999 Million	\$5 - \$9,999,999 Million	\$10 - \$14,999,999 Million	\$15 – \$24,999,999 Million	Over \$25 Million
One Site	One Program	\$950	\$1655	\$2330	\$3200	\$4500	\$5500
Multiple Sites	One Program	\$1060	\$1760	\$2740	\$3700	\$5250	\$6250
One Site	Multiple Programs	\$1175	\$1875	\$3110	\$4200	\$6000	\$7250
Multiple Sites	Multiple Programs	\$1275	\$1975	\$3465	\$4600	\$6750	\$8250

Payment Information: Determine your dues amount using the chart above.

Company Name: _____

Amount of Dues Based on ①, ②, & ③ _____

Less 2% if payment is **paid by check:** _____

Balance Due: _____

Voluntary Round-Up/Increase: _____

TOTAL AMOUNT ENCLOSED: _____

If paying by Credit Card, please complete the following information and fax or mail (do not email) —Please print legibly

Name as it appears on card: _____

CC#: _____ Visa MC Discover Am. Express

Billing Address: _____ City, State, Zip _____

Exp. Date: _____ CVC(3 or 4 digit code) _____ Signature: _____

Verification: I certify that all information provided in the Provider Membership Application is accurate.

Authorized Signature

Title

Date

Important Information: MAHC is exempt from income tax under Internal Revenue Code 501(c)(6) as a trade association and, as such, dues and/or contributions to MAHC do not qualify as deductible charitable contributions.

Please Note: Due to congressional action which eliminates the deductibility of lobbying expenses, MAHC reasonably estimates that only 90% of MAHC membership dues may be deductible as an “ordinary and necessary business expense” for federal income tax purposes. Consult an attorney or tax advisor if you require further information on this law.

Complete BOTH sides of this application & return it with payment and tax exempt status letter to:

Missouri Alliance for HOME CARE

2420 Hyde Park, Suite A

Jefferson City, MO 65109-4731

Phone (573) 634-7772 Fax (573) 634-4374

