Provider Membership Application

California Association for Health Services at Home
3780 Rosin Court, Ste. 190, Sacramento, CA 95834
Phone: (916) 641-5795 | Fax: (916) 641-5881 | www.CAHSAH.org

CAHSAH
Shaping the Future of Home Care

APPLICATION MUST BE COMPLETED TO BE CONSIDERED FOR MEMBERSHIP.

I. COMPANY INFORMATION

☐ New Member ☐ Renewing Member

Agency Name: _____

Mailing Address: _____ _____

City, State, Zip: _____

Phone Number: _____ Fax: _____ Email: _____

Website: _____

Do you have other locations? _____Yes _____No *If yes, please provide (page 4) to CAHSAH at membership@cahsah.org.*

Has your agency or any other agency with which you have been affiliated ever had their CAHSAH Home Care Aide Organization Certification or CAHSAH membership revoked or denied? _____Yes _____No *If yes, please explain:* _____

_____

II. STAFF INFORMATION

Please add a Key Contact, Voting Delegate (if different than the Key Contact) and additional staff members who will receive CAHSAH information (i.e. CEO, COO, ExecMgr, etc). If you would like to add more, please call Membership at (916) 641-5795 or e-mail: membership@cahsah.org.

Key Contact *(receives all CAHSAH publications via email)*

Name: _____

Title/Degree: _____

Email: _____

Voter Delegate *(if different from Key Contact)*

Name: _____

Title/Degree: _____

Email: _____

Additional Personnel to receive CAHSAH Email Publications:

Name: _____

Title/Degree: _____

Email: _____

Name: _____

Title/Degree: _____

Email: _____

III. SECTION INFORMATION

CAHSAH requires that members be licensed in their sections. Please provide your license number for each section in which you provide services. If the license in a section is covered by another license, please re-enter that license number. **(***Please note: License numbers are 9 digits in length.)*

Primary Section: _____
(Section type) (License #)

Secondary Sections:

☐ Home Care Aide (HCA) License # _____
☐ Licensed Home Health (LHH) License # _____
☐ Medicare Certified (MC) License # _____
☐ Hospice (H) License # _____
☐ Home Medical Equipment (HME) License # _____
☐ Home Infusion Pharmacy (HIP) License # _____
☐ Interdisciplinary Professional Services

Note: A copy of your state license is required, submit to CAHSAH by fax (916) 641-5881 or e-mail: membership@cahsah.org.

IV. CONDITIONS OF PARTICIPATION

1. Provider Membership in CAHSAH is open to direct providers of health and supportive services and products in the home.
2. Adherence to CAHSAH Code of Ethics.
3. Membership benefits begin with receipt of payment and continue for one year. Only employees of the member entity may utilize member benefits.
4. Dues are based on the number of licenses your agency holds and the number of branches/additional licensed locations serving your patients and clients. See page 2 for Dues Schedule.
5. Membership dues and voluntary contributions are non-refundable.
6. Dues payments to CAHSAH are not deductible as a charitable contribution for federal income tax purposes. However, dues payments may be deductible as an ordinary and necessary business expense, subject to an exclusion for lobbying activity. Because a portion of your dues is used for lobbying by CAHSAH, 17% of your dues is not deductible for income tax purposes.

I, as CEO, CFO or Executive Management, have read, understand and agree to abide by the Conditions of Participation. I further certify that I have accurately represented my agency's information.

Signature: _____ Date: _____

Name (please print): _____ Title: _____

Agency Name_____

PROVIDER DUES SCHEDULE

CAHSAH dues are based on the number of licenses your agency holds and the number of branches/additional licensed locations serving your patients and clients.

- **Minimum dues** $1,500 and **Maximum dues** $15,000
- **Home Care Aide** - $1,500 for initial license and $750 for each additional licensed locations
- **Home Health and Hospice** - $1,500 per license and $750 for each additional branch locations
- **Startups** receive a one year rate of $750 then transition to new dues schedule

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Questions? Call (916) 641-5795

V. CALCULATE YOUR DUES

Note: A copy of your state license is required, submit to CAHSAH by fax (916) 641-5881 or e-mail: membership@cahsah.org.

Start up Agency: *Applies to first year in business only! Quarterly payment option not available.* **$750.00**

Agency:

(Step 1.) Enter # of licenses held (HCA, LHH, Hosp) _____ x $1,500 **= $** _____

OR

- If you are licensed separately to provide either HME or HIP services, enter $1,500.
- If you are provide Interdisciplinary Professional Services, enter $1,500. **= $** _____

(Step 2.) Enter # of branches/additional licensed locations _____ x $750 **= $** _____

Subtotal = $ _____

(Step 3.) Voluntary Contributions (Optional) **= $** _____

☐ PAC (Political Action Committee) $ _____ ☐ LAF (Legislative Action Fund) $ _____

☐ CLDF (CAHSAH Legal Defense Fund) $ _____

PAC/LAF contributions are not deductible as charitable contributions. (10-25% of your total dues suggested)

Total Membership Dues = $ _____

Quarterly Payment Option:
To make quarterly payments, a one-time setup fee of $100.00 will be applied to your first quarter dues. The remaining three (3) quarters will be invoiced via e-mail.

(Step 4.) Divide Subtotal by 4 **= $** _____

(Step 5.) Add Setup fee $100.00 **= $** _____

(Step 6.) Voluntary Contributions (Optional) **= $** _____

Total First Quarter Dues = $ _____

VI. PAYMENT INFORMATION

By signing this application, you are committing to one (1) year of membership and payment of all monies due.

Please check for of payment: ☐ Check/Check No:_____ ☐ Visa ☐ MasterCard ☐ American Express

Credit Card #_____ Exp/Date:_____

Name (appears on card): _____

Billing Address: _____

City, State, Zip: _____

Signature:_____

Agency Name_____

PROVIDER DEMOGRAPHICS

Payments Accepted

____ HMO
____ Medi-Cal
____ Medicare
____ Private Insurance
____ Private Pay
____ TRICARE/CHAMPUS
____ Veterans Administration
____ Workers Comp

Accreditations

____ ACHC
____ CHAP
____ JCAHO

List of Counties

Please check the counties in which your agency provides services.

Northern, CA

___ Alameda
___ Butte
___ Colusa
___ Contra Costa
___ Del Norte
___ El Dorado
___ Glenn
___ Humboldt
___ Lake
___ Lassen
___ Marin
___ Mendocino
___ Modoc
___ Napa
___ Nevada
___ Placer
___ Plumas
___ Sacramento
___ San Francisco
___ San Mateo
___ Santa Clara
___ Santa Cruz
___ Shasta
___ Sierra
___ Siskiyou
___ Solano
___ Sonoma
___ Sutter
___ Tehama
___ Trinity
___ Yolo
___ Yuba

Central, CA

___ Alpine
___ Amador
___ Calaveras
___ Fresno
___ Inyo
___ Kern
___ Kings
___ Madera
___ Mariposa
___ Merced
___ Mono
___ Monterey
___ San Benito
___ San Joaquin
___ Stanislaus
___ Tulare
___ Tuolumne

Southern, CA

___ Imperial
___ Los Angeles
___ Orange
___ Riverside
___ San Bernardino
___ San Diego
___ San Luis Obispo
___ Santa Barbara
___ Ventura

List of Services

Please check the services your agency provides.

___ 24/7 Delivery Services
___ AIDS Patients
___ Attendant/Companion/Sitter
___ Continuous Care Nursing
___ CPR Classes
___ Elder Care/Geriatric Management
___ Enteral Feeding Supplies & Equipment
___ Enterostomal Therapy
___ Home Care Aide
___ Home Medical Equipment
___ Hospice
___ Hospital & Clinical Consultation
___ Household Management
___ Infusion Therapy
___ Medical Social Services
___ Mental Health Services
___ Multi-lingual Medical Social Services
___ Multi-lingual Staff
___ Nanny Care
___ Occupational Therapy
___ Oncology
___ Oral Supplements
___ Perinatal/Pediatric Care
___ Physical Therapy
___ Registered Dietician Support
___ Rehabilitation Services
___ Respite Care
___ Skilled Nursing
___ Speech Language Pathology
___ Speech Therapy

Organizational Information - Optional

To be used for statistical purposes only.

Statistics

Number of Full Time Employees: _____
Number of Part Time Employees: _____
Are you a member of your local Regional Council? _____
Council Name: _____

Auspice

Please check one

____ For profit
____ Non profit
____ Government
_____ Free standing
_____ Hospital based

Membership Source:

How did you hear about CAHSAH: _____

Agency Name________________________________

BRANCHES/ADDITIONAL LICENSED LOCATIONS INFORMATION

Agency Name: ____ License #:______________________
Mailing Address: ____
City, State, Zip: ____
Phone Number: ______________________ Fax: ___________________ E-mail: ______________________
Key Contact/Title:____
Key Contact E-mail: ____

Agency Name: ____ License #:______________________
Mailing Address: ____
City, State, Zip: ____
Phone Number: ______________________ Fax: ___________________ E-mail: ______________________
Key Contact/Title:____
Key Contact E-mail: ____

Agency Name: ____ License #:______________________
Mailing Address: ____
City, State, Zip: ____
Phone Number: ______________________ Fax: ___________________ E-mail: ______________________
Key Contact/Title:____
Key Contact E-mail: ____

Agency Name: ____ License #:______________________
Mailing Address: ____
City, State, Zip: ____
Phone Number: ______________________ Fax: ___________________ E-mail: ______________________
Key Contact/Title:____
Key Contact E-mail: ____

Agency Name: ____ License #:______________________
Mailing Address: ____
City, State, Zip: ____
Phone Number: ______________________ Fax: ___________________ E-mail: ______________________
Key Contact/Title:____
Key Contact E-mail: ____

Agency Name: ____ License #:______________________
Mailing Address: ____
City, State, Zip: ____
Phone Number: ______________________ Fax: ___________________ E-mail: ______________________
Key Contact/Title:____
Key Contact E-mail: ____

If additional space is required, please use separate page and include with application.