Hudson Valley Chapter | **Provider Application for Chapter Membership 2022-23**

Providers must be members of HCP at the State level in order to be eligible for Chapter participation.

❑ **New Member** ❑ **Renewing Member**

Organization Name:____

d/b/a:______________________________ Year Established:______________________

Address:____

City:______________________State:________________Zip:__________________

Phone:______________________________ Fax:______________________________

Main Contact:____________________________ Title:____________________________

E-mail Address: ____

Corporate type: (check one) ❑ Not-for-profit ❑ Proprietary

Chapter 2022-23 Dues

The Hudson Valley Chapter dues year runs November 1 through October 31. Provider membership for each organization in the Hudson Valley Chapter of the New York State Association of Health Care Providers, Inc. (HCP) includes all related New York State home care corporations, subsidiaries and other entities under common ownership and/or management.

Annual Dues for Hudson Valley Chapter Provider membership are $250.

Note: First-time members who join mid-year are pro-rated for the remainder of the dues year.

Payment – Electronic Payment Preferred – See Attached Paypal Invoice

All members are encouraged to satisfy their dues obligation in entirety at the start of the dues year.

Total Due: ____________________ Amount Enclosed: ________________

Make check payable to: Hudson Valley Chapter of the New York State Association of Health Care Providers, Inc.

Note: Chapter dues are not deductible as a charitable contribution for federal tax purposes, but may be deductible as a business expense as well as an allowable Medicare expense. However, in accordance with Section 13222 of OBRA 1993 (Denial of the Deduction for Lobbying Expenses), 9% of your membership dues are not tax deductible as ordinary and necessary business expenses.

Signature: ____

Title: ____

Thank you for joining the Hudson Valley Chapter. Please be sure to complete both sides of this application and return with payment to:

c/o Glenn Lane
Re: Hudson Valley Chapter of NYSHCP
Westchester Family Care Inc., 1 Depot Plaza
Mamaroneck, NY 10543
(914) 764-7505
glenn.lane@westfamilycare.com

Please call with any questions.

President: Glenn E. Lane, Westchester Family Care Inc., 914.764.7500
Vice President: Eric Dalton, Angels On Call Homecare, LLC., 845.628.2255

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HCP Hudson Valley Chapter
Provider Application for Chapter Membership 2022-23

Instructions

Complete this section for each office of your organization where you would like to receive Chapter information. Please copy this page, complete and attach for any additional locations. Please type or print neatly.

Organization Name:____

d/b/a:______________________________ Year Established:__________________

Address:____

City:____________________State:________________Zip:__________________

Phone:______________________________ Fax:______________________________

Main Contact: ____________________ Title: ____________________ Email:________________

Addtl Contact: ____________________ Title: ____________________ Email:________________

Is this organization a certified NYS Minority and Women Owned Business Enterprise (MWBE)? ❑ Yes ❑ No

Should this office receive information sent to all Chapter members? ❑ Yes (note: information will go to 1st contact) ❑ No

What type of office is listed on this form? (check one)

❑ Corporate Headquarters ❑ Franchise ❑ Main Office ❑ Branch Office
❑ Recruiting Office ❑ Satellite Office ❑ Other:____________________

What services are provided by this location? (check all that apply)

❑ LHCSA ❑ CHHA ❑ Companion Agency
❑ LHCSA affiliated w/ALP ❑ Special Purpose CHHA ❑ Hospice
❑ License pending ❑ CDPAS FI ❑ Other:____________________

Is this office accredited? (check all that apply)

❑ JCAHO ❑ CHAP ❑Other:____________________

Organization Name:____

d/b/a:______________________________ Year Established:__________________

Address:____

City:____________________State:________________Zip:__________________

Phone:______________________________ Fax:______________________________

Main Contact:______________________________ Title:______________________________

Additional Contact: ____________________________ Title: ______________________________

Is this organization a registered NYS Minority and Woman Owned Business Enterprise (MWBC)? ❑ Yes ❑ No

Should this office receive information sent to all Chapter members? ❑ Yes (note: information will go to 1st contact) ❑ No

What type of office is listed on this form? (check one)

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Is this office accredited? (check all that apply)

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Thank you for joining the HCP Hudson Valley Chapter. Please be sure to complete both sides of application and return with payment.