



**Northeastern New York 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 Northeastern New York Chapter dues year runs November 1 through October 31.** Provider membership for each organization in the Northeastern New York 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 Northeastern New York Chapter Provider membership are \$200.**

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

**Payment**

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: Northeastern New York 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 Northeastern New York Chapter. Please be sure to complete both sides of this application and return with payment to:** Cindy Siwek at North Country Home Services, 18 Montcalm Street, Ticonderoga, NY 12883. 518.585.9820

**Please call any of the HCP Northeastern New York Chapter Board Members with any questions.**

President, Jennifer Barnett, JBarnett@belvedereservices.com, Belvedere of Albany, 518.694.9400  
Vice-President, Trish McKinney, tmckinney@adkha.org, Greater Adirondack Home Aides, 518.926.7070  
Secretary, Karen Clark, kclark@newyorkhomehealthcare.com, Home-Health Care Partners, 518.848.3277  
Treasurer, Cindy Siwek, csiwek@nchs.net, North Country Home Services, 518.585.9820

**Please be sure to complete both sides of application and return with payment.**

**HCP Northeastern New York 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: \_\_\_\_\_

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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

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**Thank you for joining the HCP Northeastern New York Chapter!**