



**AGENCY MEMBERSHIP  
2021 Application Form**

Check one:                                      **Renewal**                       **New Member**

**Agency Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Contact Email address:** \_\_\_\_\_

Agency Membership dues are based on your 2020 home care aide payroll per the following schedule (**Please check the Dues Tier that applies to your agency:**)

|                          | <u>Tier</u> | <u>Home Care Aide Payroll</u> | <u>Agency Membership Dues</u> |
|--------------------------|-------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> | 1           | Less than \$500,000           | \$750                         |
| <input type="checkbox"/> | 2           | \$500,000 - \$999,999         | \$1,500                       |
| <input type="checkbox"/> | 3           | \$1,000,000 - \$1,999,999     | \$2,000                       |
| <input type="checkbox"/> | 4           | \$2,000,000 - \$2,999,999     | \$2,500                       |
| <input type="checkbox"/> | 5           | \$3,000,000 - \$4,999,999     | \$3,000                       |
| <input type="checkbox"/> | 6           | \$5,000,000 - \$6,999,999     | \$5,000                       |
| <input type="checkbox"/> | 7           | \$7,000,000 or over           | \$7,000                       |

Please indicate your corporate-wide 2020 Home Care Aide wages \$\_\_\_\_\_ (Agencies choosing not to submit payroll data will be charged dues of \$7,000)

*I confirm that the information completed above is complete and accurate. I understand that my company's membership dues are not refundable and dues payment must be paid in full within six (6) months from the date listed below. In the event that my company should be sold or merged with another firm, I understand my firm is still responsible for the remaining balance of its membership dues.*

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

*Please note that 9.4% of your 2021 Annual dues are not tax deductible because they are associated with lobbying activities.*



## PAYMENT INFORMATION

- Dues Enclosed: Amount Paid: \$ \_\_\_\_\_
- Please Bill Me:
- One Payment
- Two Payments (**This Payment Option is Available for Tier 3-7 only**)

Checks can be made payable to: Home Care Aide Council

To pay by credit card (VISA, MasterCard, American Express only), please complete the information below.

Card Number \_\_\_\_\_

Exp. Date \_\_\_\_/\_\_\_\_ (Month/Year)

VISA/MasterCard 3-digit code on reverse \_\_\_\_\_ American Express 4-digit code on front \_\_\_\_\_

Cardholder's Name \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature of Cardholder \_\_\_\_\_

Please return this form and payment to the Council office by mail at the address below or email to [layala@hcacouncil.org](mailto:layala@hcacouncil.org).

Home Care Aide Council  
P.O. Box 535  
Somerville, MA 02143



**QUESTIONNAIRE FOR LISTING IN THE COUNCIL’S 2020 MEMBER DIRECTORY**

The listing of all Council Agency members is now available on our website [www.hcacouncil.org](http://www.hcacouncil.org). Please review the information below which is contained in your current Directory listing. If you need to make any changes to your listing, please correct below and return to the Council. Or, you may now also log into the “Member’s Only” portal of our website to make these corrections. **If your agency has branch offices that are fully staffed, please duplicate the form and fill out for each branch office.**

The below information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Agency Name:**

**Address:**

**City:**

**State:** MA

**Zip:**

**Telephone:**

**Fax:**

**Website:**

**Please check all that apply:**

|                          |                                |
|--------------------------|--------------------------------|
| <input type="checkbox"/> | Certified Agency               |
| <input type="checkbox"/> | EOEA Contract Agency           |
| <input type="checkbox"/> | MRC Contract Agency            |
| <input type="checkbox"/> | JCAHO Accredited               |
| <input type="checkbox"/> | CHAP Accredited                |
| <input type="checkbox"/> | Private Pay Services Available |

**Please check all that apply:**

Is your agency affiliated with a certified agency?

Is your agency affiliated with a hospital?

Is your agency a franchise?

**If your agency is part of an “umbrella” agency, please list your affiliate agencies in Massachusetts:**

**Type of services available through your agency (Please check all that apply):**

|   |   |  |  |
|---|---|--|--|
| 24/7<br>Case Management<br>Child/Maternity Care<br>Chore<br>Companion | Evening<br>Hands-on Non-Skilled<br>Holiday<br>Home Health Aide<br>Homemaker | Hospice/ End-of-Life<br>Live-Ins<br>Medication Reminders<br>Nursing<br>Overnight | Personal Care Homemaker<br>Supportive Home Care Aide<br>Transportation<br>Weekend<br>Other, please specify |
|---|---|--|--|



**Cities/Towns served:**

- |               |               |
|---------------|---------------|
| City/Town 1:  | City/Town 16: |
| City/Town 2:  | City/Town 17: |
| City/Town 3:  | City/Town 18: |
| City/Town 4:  | City/Town 19: |
| City/Town 5:  | City/Town 20: |
| City/Town 6:  | City/Town 21: |
| City/Town 7:  | City/Town 22: |
| City/Town 8:  | City/Town 23: |
| City/Town 9:  | City/Town 24: |
| City/Town 10: | City/Town 25: |
| City/Town 11: | City/Town 26: |
| City/Town 12: | City/Town 27: |
| City/Town 13: | City/Town 28: |
| City/Town 14: | City/Town 29: |
| City/Town 15: | City/Town 30: |

Additional Cities/Towns: \_\_\_\_\_

**Counties served (Please check all that apply):**

- |             |            |            |
|-------------|------------|------------|
| Barnstable: | Franklin:  | Norfolk:   |
| Berkshire:  | Hampden:   | Plymouth:  |
| Bristol:    | Hampshire: | Suffolk:   |
| Dukes:      | Middlesex: | Worcester: |
| Essex:      | Nantucket: |            |

**PLEASE RETURN BY MAIL TO:**

**Home Care Aide Council  
P.O. Box 535  
Somerville, MA 02460  
layala@hccouncil.org**

**OR BY EMAIL TO**