



317 State Street, Augusta, Maine 04330 • Tel. (207) 623-1146 • Fax (207) 623-4080

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## APPLICATION FOR MEMBERSHIP

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### **MHCA's Mission:**

The Maine Health Care Association is a statewide association of providers of services to Maine's older and disabled populations. MHCA represents more than 300 assisted living/residential care facilities, nursing facilities, skilled nursing facilities, adult day service providers, home health service providers, independent living/congregate housing providers, rehabilitation providers, and other organizations and individuals who provide housing, health care and supportive services to more than 10,000 Maine residents.

**The mission of the Maine Health Care Association is to promote and advance the delivery of high quality health care, housing and supportive services to meet the needs of Maine's older and disabled populations. The Association achieves its mission through:**

- Educating the public.
- Advocating on behalf of consumers and providers.
- Building a high-quality work force.
- Developing management excellence and leadership capability of its members.
- Promoting the business effectiveness and efficiency of its members.

### **Types of Membership Available:**

**Full Membership.** Full membership may be granted to any assisted living/residential care facility, nursing facility, skilled nursing facility, adult day service provider, home health service provider, independent living/congregate housing provider, rehabilitation provider, which is licensed and/or certified by the State of Maine. All facilities/agencies are eligible for full membership and each is entitled to all rights and privileges, including the right to vote and seek office. A single licensed facility/agency within a "multi-facility" shall not be eligible for membership in association unless all facilities/agencies within said "multi-facility" pay annual dues and any special assessments levied against the entire membership, unless a hardship waiver is granted as provided in ARTICLE IV, SECTION 5, of the MHCA's by-laws.

**Associate Organizational Membership.** Associate organizational membership may be granted to groups or individuals, real or corporate, who are engaged in activities which relate to the objectives of the association, and are not eligible as member facilities/agencies. Associate organizational members may attend all general membership meetings, annual business meetings, conventions and association sponsored education programs at the member rate. However, associate organizational members are ineligible to serve on the Board of Directors, hold office or vote at the annual meeting. Associate organizational members are eligible to serve on committees of association in a voting capacity. Management corporations, whose clientele is eligible for membership, are ineligible for Associate Organizational membership.

**Associate Personal Membership.** Associate personal membership is available to an individual who is not employed by, is not an owner of an aforementioned organization, or has no immediate family member holding 10% or more ownership rights in any type of health care organization which is eligible for association membership. Associate personal members shall not be eligible to hold office or vote in the affairs of association. Associate personal members may attend all general membership meetings, annual business meetings and conventions, association-sponsored education programs at the membership rate, and shall be eligible to serve on committees of association in a voting capacity.

## Dues Structure:

**Full Membership:** Dues shall be calculated as a percentage of a facility's or agency's net patient service revenues, with a minimum rate of \$250.00. The board of directors shall establish the percentage each year based on the association's budget needs and its projected revenues from other activities. Using the data from your most recently completed fiscal year, and based on each type of service provided, please indicate your net patient service revenue or, if you are an independent living/housing provider, your gross rental income. **See Explanation of Net Patient Service Revenue Calculation below.**

Indicate fiscal year used for completing the following information: \_\_\_\_\_

Adult Day Services Program	_____	(net patient service revenue)
Assisted Living Program (formerly Congregate Types 3 and 4)	_____	(net patient service revenue and/or gross rental income)
Residential Care Levels 3 and 4 (Levels 1 & 2 see*)	_____	(net patient service revenue)
Home Health Care	_____	(net patient service revenue)
Independent Housing with Services (formerly Congregate Types 1 and 2)	_____	(gross rental income)
Nursing Facility/SNF	_____	(net patient service revenue)
Total Annual Patient Service Revenue/Rental Income	_____	
	x 0.075% (percentage determined on an annual basis)	
	_____	MHCA Dues (minimum \$250)*
	_____	AHCA/NCAL (national affiliate) (see below for per bed charge)

**Associate Organizational Membership:** \$400

**Associate Personal Membership:** \$100

**American Health Care Association/NCAL:** Dues based on per bed fee—\$20.60/bed for NFs;  
\$10.50/per bed AL/RC.

National affiliation dues are separate from MHCA dues.

\*Note: Facilities that have 6 beds or less will be charged a flat fee of \$250.00.

**Explanation of Net Patient Service Revenue Calculation:** *Net Patient Service Revenue* = Gross patient service revenue minus contractual allowance. *Gross Patient Service Revenue* = Room and board charges at established standard rates plus ancillary charges at established standard rates. Revenue is recorded on the accrual basis; when services are provided. *Contractual Rate Revenue* = Third party reimbursements at reduced rates from standard charges noted above (i.e. Medicaid, Medicare) and cost settlement. Adjustments related to retrospective cost settlements or estimates for current year based on interim payment rates. Provider tax revenue and Staff enhancement payments are included in the contractual rate as it is included in the Maine Care rate letters. *Contractual Allowance* = Gross patient service revenue minus the contractual rate revenue. Bad debts and bad debt allowances are excluded from the above calculations. Provider Tax Revenue should be part of the contractual Medicaid rate.

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**The membership year runs from October 1 – September 30. Dues will be prorated based on when the organization or individual joins.**

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If you have any questions regarding completion of the application for membership, please contact: Dianne Chicoine (Email: [dchicoine@mehca.org](mailto:dchicoine@mehca.org)), Maine Health Care Association, 317 State Street, Augusta, Maine 04330 Tel: 207/623-1146 Fax: 207/623-4080

# APPLICATION FOR MEMBERSHIP

Please complete all applicable information requested. This information is for the association's database.

Contact Person:		Title:	
Facility Name:			
Address:			
City:	State:	Zip Code:	
Tel. No.:		Fax No.:	
Email:		Website:	
<b>Corporate Status:</b>			
<input type="checkbox"/> For Profit – Corporation	<input type="checkbox"/> For Profit – Individual	<input type="checkbox"/> For Profit – Partnership	
<input type="checkbox"/> Non Profit – Church Affiliated	<input type="checkbox"/> Non Profit – Corporation	<input type="checkbox"/> Non Profit – Other	
<input type="checkbox"/> Non Profit – Hospital Affiliated	<input type="checkbox"/> Government – City	<input type="checkbox"/> Government – State	
<b>Complete the following information on all persons and/or corporations holding 10% or more ownership.</b>			
Owner(s):			
Corporate Office Name:			
Address:			
City:	State:	Zip Code:	
Tel. No.:		Fax No.:	
Email:		Website:	
<b>Complete the following information if your organization is being <u>managed</u> by a separate organization.</b>			
Contact Person:			
Management Office Name:			
Address:			
City:	State:	Zip Code:	
Tel. No.:		Fax No.:	
Email:		Website:	

**For those applying for Full Membership, indicate the current number and types of licensed beds/units:**

Number	Types of Licensed Beds/Units in Facility	Number	Types of Licensed Beds/Units in Facility
	Adult Day Services Programs		Level III Residential Care Facility <input type="checkbox"/> PNMI
	Assisted Living Program (Formerly CHSP3/4)		Level IV Residential Care Facility <input type="checkbox"/> PNMI
	Dual (Dually Certified NF)		Nursing Facility
	ICF/MR Nursing Facility		Skilled Nursing Facility
	ICF/MR Group Home		Acute
	Independent Housing With Services (Formerly CHSP1/2)		Psychiatric
	Level I Residential Care Facility <input type="checkbox"/> PNMI		Swing
	Level II Residential Care Facility <input type="checkbox"/> PNMI		

**For those applying for Full Membership, check each service currently offered by the facility:**

✓	Service(s) Provided	✓	Service(s) Provided
	Alzheimer's Care		Rehabilitation
	Home Health Care		Respite Care
	Hospice Care		

**For those applying for an Associate Organizational membership:**

Nature of business activity:

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Does this organization hold 10% or more ownership rights in any type of health care organization, which is eligible for MHCA membership?  Yes  No

**For those applying for an Associate Personal membership:**

Occupation: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Describe briefly our interest in long-term care and in the association:

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Do you or a member of your immediate family (spouse, sibling, child, father, mother or in-law) hold 10% or more ownership rights in any type of health care organization, which is eligible for MHCA membership?  Yes  No

Are you employed in any type of health care organization, which is eligible for MHCA membership?  Yes  No

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Please enclose with your application any brochures or other descriptive material you may have related to your facility and its program.

Approval of this application will be based in part upon the information supplied herein. Falsification or misrepresentation of any information considered part of this application would result in disqualification for membership in the Maine Health Care Association.

Contributions or gifts to the MHCA are not deductible as charitable contributions for federal income tax purposes. Dues/ payments may be deductible by members as an ordinary and necessary business expense.

CERTIFICATION: I certify that the information provided in this application is accurate and complete to the best of my knowledge. The undersigned, if admitted to active membership in the MHCA, hereby agrees that it will in all respects conform to and abide by the bylaws of MHCA and all amendments hereafter made thereto.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Title: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

Date Received Application: \_\_\_\_\_

Date Evaluated by Board of Directors: \_\_\_\_\_

Disposition of Application: \_\_\_\_\_