PCQPAC

Pennsylvania Coalition for **Quality** Post-Acute Care

# PCQPAC Membership Agreement

I, _____, certify that I am authorized to sign the binding agreement listed below on behalf of the following facility(s):

_____

- I authorize all agents of PCQPAC, including its contracted attorneys and lobbyists, to represent my facility in negotiations with the Pennsylvania Department of Human Services.
- I authorize all agents of PCQPAC, including its contracted attorneys and lobbyists, to represent my facility during negotiations with the following Community Health Choices Managed Care Organizations: AmeriHealth Caritas, Keystone First Community HealthChoices (AmeriHealth Southeast), PA Health & Wellness, and UPMC Community HealthChoices.
- I acknowledge that I will be represented by PCQPAC with respect to operational issues and disputes that may arise with the CHC MCOs. I appoint PCQPAC and its agents to act as a representative of my facility in regards to these issues.
- I understand that my facility's Medicaid reimbursement rates may change as a result of negotiations with the CHC MCOS.
- I agree to pay annual member dues of $30 per certified bed in my facilty(s). These fees are capped at $30,000 for multi-facility organizations with common ownership. Membership will run annually from the initial date of membership.
- I acknowledge that my facility will not be a member of PCQPAC or represented by PCQPAC until my annual member dues are paid in full.
- I affirm that my facility has a current CMS rating between 3 –5 stars or had a 3 –5 star CMS rating during the last 2 quarterly reporting periods. I understand that the PCQPAC Board may vote to amend or supplement these Quality Care Parameters in the future. I am aware that my facility will no longer be eligible for membership if my facility falls below the established parameters upon membership renewal.
- I understand that PCQPAC's Board has the power to vote to amend or supplement this agreement and modify membership fees if there is a change or increase in the scope of services.
- I affirm that an agent of my facility will accurately complete all surveys that are distributed by PCQPAC. I understand that the data collected will be shared with PCQPAC's contracted lobbyists and attorneys.
- I have received PCQPAC's Organizational By-laws and understand that the Board retains decision-making power and will vote on organizational issues as they arise. I understand that I am encouraged to submit comments and feedback for Board consideration.

I have read the above statements, understanding that my signature authorizes PCQPAC to advocate and negotiate on my facility's behalf.

_____ _____

First & Last Name (printed) Job Title at Facility

_____ _____

Signature Date

PCQPAC

Pennsylvania Coalition for **Quality** Post-Acute Care

# Member Information Form

**Facility Information:**

Name of Facility: _____

Corporate/ Parent Company: _____
(If applicable)

Address of Facility: _____

Current CMS Star Rating: _____

Medicare Provider #: _____ Medicaid Provider #: _____

CHC Managed Care Region: _____ # of Certified Beds: _____

If you have more than one facility joining PCQPAC, please list each facility on the attached next page.

**Primary Contact Person for Facility (this person will receive PCQPAC updates):**

First & Last Name: _____

Position at Facility: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

**Secondary Contact for Facility (this person will receive PCQPAC updates):**

First & Last Name: _____

Position at Facility: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Additional Person(s) who should receive PCQPAC updates:

_____

**Please fill out a form for each facility that will be joining PCQPAC.**

## Additional Facility Joining PCQPAC:

PCQPAC
Pennsylvania Coalition for Quality Post-Acute Care

**Facility Information:**

Name of Facility: _____

Address of Facility: _____

Medicare Provider #: _____ Medicaid Provider #: _____

Current CMS Star Rating: _____

CHC Managed Care Region: _____ # of Certified Beds: _____
(SE, SW, or "Other" Region)

**Contact Person for Facility (this person will receive PCQPAC updates):**

First & Last Name: _____

Position at Facility: _____

Email Address: _____

Phone Number: _____ Fax Number: _____


## Additional Facility Joining PCQPAC:

PCQPAC
Pennsylvania Coalition for Quality Post-Acute Care

**Facility Information:**

Name of Facility: _____

Address of Facility: _____

Medicare Provider #: _____ Medicaid Provider #: _____

Current CMS Star Rating: _____

CHC Managed Care Region: _____ # of Certified Beds: _____
(SE, SW, or "Other" Region)

**Contact Person for Facility (this person will receive PCQPAC updates):**

First & Last Name: _____

Position at Facility: _____

Email Address: _____

Phone Number: _____ Fax Number: _____