

**Hawaii Waiver Providers Association
Membership Application**

Agency Name: _____

Address: _____

City/State/Zip _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Designated Voting Member (name and position): _____

Phone: _____ Fax: _____ Email: _____

Check DD/MR Waiver Services your agency provides:

_____ Day Services Level 1	_____ Personal Assistance Level 1
_____ Day Services Level 2	_____ Personal Assistance Level 2
_____ Day Services Level 3	_____ Personal Assistance Chore
_____ Habilitation	_____ Skilled Nursing
_____ Habilitation Supported Employment	_____ Respite

Membership Level: First Year _____ Basic _____ Sustaining _____ Charter _____

Prior Fiscal Year DD/MR Waiver Revenues: _____

Dues Amount: \$ _____

(Sustaining and Charter members may make payments in increments providing the first payment is at least as much as the basic membership dues)

Make check payable to HWPA and mail to: HWPA
c/o SECOH
708 Palekua St.
Honolulu, HI 96816

Date of Application: _____

Dues Schedule

Basic Membership: (First year members only)	\$100
Basic Membership (2nd year and beyond)	
Annual Medicaid Waiver Revenues	
\$250,000 and under.	\$150
\$250,000 to \$500,000	\$300
\$500,000 to \$1,000,000	\$500
\$1,000,000 to \$2,000,000	\$700
\$2,000,000 or more	\$1,000
Sustaining Member:	\$3,000
Charter Member:	\$5,000