National Hospice and Palliative Care Organization

AFFILIATE MEMBERSHIP APPLICATION

Affiliate Membership is designed specifically for a group supportive of the hospice and/or palliative care mission, vision and standards and program of care such as a hospice foundation, home health agency, or grief/bereavement program. Affiliate Membership is not available to organizations that are reimbursed for hospice care or that qualify for another category of NHPCO membership including Provider, Palliative Care, or Associate. Organizations serving patients and being reimbursed for hospice care must apply for Provider Membership.

General Information

Organization Name _____

Contact Name _____ Title _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____ Web Site _____

❑ NHPCO respects your privacy. NHPCO will not sell, rent or distribute your e-mail address to any outside organization. NHPCO intends to use this medium to communicate membership related notices and benefits, as well as NHPCO related services, such as conference information and NHPCO Marketplace product announcements and sales. If you would prefer not to be included in the e-mail distribution list please check the preceding box.

❑ On occasion, NHPCO makes its membership list available to hospice-oriented vendors and educators. Please check here if NHPCO should not release your name to such vendors.

❑ Do not list this program in the NHPCO Membership Directory.

Company description *(up to 30 words)* _____

_____

Please indicate your primary type of business *(please check only one box)*

❑ Accreditation
❑ Assisted Living
❑ Companion Service
❑ End of Life Care
❑ Foundation
❑ Grief & Bereavement Center
❑ Home Health Agency
❑ Religious Organization
❑ Research and Education
❑ Staffing Agency/Service
❑ Other (please describe): _____

_____

What is your primary reason for joining NHPCO? _____

_____

Affiliate Membership dues are $200 per year *(based on anniversary date)*.....$ 200.00

❑ **My company wants to sign up for the MSDS Program.**
I understand the additional cost is $60.....$ 60.00

TOTAL FEE $

❑ VISA ❑ MasterCard ❑ ❑ **Check Enclosed** (payable to NHPCO) **CK#**_____

Card Number _____ Exp. Date _____

Name on Card (Print) _____

Authorized Signature _____

❑ **I hereby certify that my organization is not a hospice, and that everything stated in this form is correct and complete to the best of my knowledge.**

Name of Person Completing Form (Print) _____

Signature _____ Date _____

(Office Use Only)

Type _____
ID# _____
Payment _____
Initial _____
Date _____

Please return this form with payment to:

NHPCO, Department 929, Alexandria, VA 22334-0929 or fax to 703-837-1233

Questions? Call NHPCO's Member Service Center at

800-646-6460