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## 2004 PALLIATIVE CARE PROVIDER ACTIVATION FORM

**Primary Contact\***

**Title**

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**Hospital/Program**

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**Address**

**City**

**State**

**Zip**

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\*Person who will receive all Provider mailings from NHPCO, be listed as the as the primary contact on the NHPCO Web site and Membership Directory, and serve as Voting Delegate.

Palliative Care Provider Dues – \$500 for membership through December 31, 2004.

**Please mail payment with completed forms to NHPCO. Make a copy of all forms for your records prior to mailing.**

My check for dues in full is enclosed.  
Check Number \_\_\_\_\_ Amount \$ \_\_\_\_\_

Charge my credit card:       Visa     MasterCard     American Express

Credit Card # \_\_\_\_\_ Exp Date \_\_\_\_\_  
Name on Card \_\_\_\_\_ Amount \$ \_\_\_\_\_  
Signature \_\_\_\_\_

**Everything stated in this form is correct and complete to the best of my knowledge.**

Signature of Person who completed form: \_\_\_\_\_

Please print name: \_\_\_\_\_

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

\*Membership dues are non-refundable. Please note that 97% of your dues payment may be tax deductible as an ordinary and necessary business expense. Approximately 3% of your membership dues payment goes toward lobbying efforts and is not tax deductible. This information is not intended as tax advice. Please contact your tax professional for tax advice.

**Questions? Call NHPCO's Membership Service Center 800/646-6460.**

**Please return all forms with payment to:**  
NHPCO, Department 929, Alexandria, VA 22334-0929

**For overnight or express delivery forward to:**  
NHPCO, Department 929, Alexandria, VA 22334-0929  
Or, fax to 703/837-1233



## 2004 PALLIATIVE CARE PROVIDER VERIFICATION FORM

This form is used to report your program's information, which will be included in the NHPCO Membership Directory, NHPCO's web site and used for referral services. Fax the completed form to 703/837-1233, or mail with your Activation Forms to NHPCO, Department 929, Alexandria, VA 22334-0929.

<b>Primary Contact*</b>	<b>Title</b>	
<b>Hospital/Program</b>		
<b>Address</b>		
<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Phone</b>	<b>Fax</b>	
<b>E-mail*</b>	<b>Web site</b>	

\*NHPCO respects your privacy. NHPCO will not sell, rent or distribute your email address to any outside organization. NHPCO intends to use this medium to communicate membership related notices and benefits, as well as conference information and NHPCO Marketplace announcements.

**Please update the following staff information:**

Medical Director:	E-mail:
Clinical Director or Nurse:	E-mail:
Education Contact:	E-mail:
Research Contact:	E-mail:
Referral Contact:	E-mail:
Spiritual Contact:	E-mail:
Social Work Contact:	E-mail:

**Program Information (check all that apply):**

- Currently Operating a Palliative Care Program     Palliative Care Program in the Planning Stages
- Currently Operating a Hospice and Palliative Care Program

What services to you provide?

- Pediatric Palliative Care     Inpatient Consultation Service
- Inpatient Palliative Care Unit     Outpatient
- Teaching Service:     Medical     Nursing     Social Work     Spiritual Care     Other

Do you have a Satellite site?     Yes     No

Medicare Certified as a Hospice:     Yes     No

Medicaid Certified for Hospice:     Yes     No

**2004 Palliative Care Program Verification Form continued – Page 2**

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Dominant Corporate Status (choose one):

- Hospital:  Private  Non Profit  For Profit  
 Palliative Care Group Practice  Hospice  Private Practice  
 Division of Home Health Agency  Division of Veterans Administration  Division of Nursing Home  
 Division of Prison  Other (HMO, PPO, DME, etc) \_\_\_\_\_

**Location:** (for more accurate referrals)

1) MSA (Major Metropolitan Area), please list **only one city name**:

2) Counties Served: **NO MORE THAN 12**; include the state abbreviation(s) if different than program locale:

3) Zip Codes: List **up to 20** zip codes that your program serves (attach additional sheet if needed):

**Other Information (for research/planning purposes only):**

Total Paid Staff \_\_\_\_\_ Total Full Time Staff Equivalentents \_\_\_\_\_ Total Volunteers \_\_\_\_\_

Primary Financial Support:  Parent Corporation  Philanthropy  Grants  Billing

We work with work the following hospice(s):

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What is your primary reason for joining NHPCO?

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**Communications from NHPCO:** (one copy to be sent to Primary Contact at your program)

My program prefers to receive *Newsline* (currently mailed once a month) via:  Mail  Email

My program prefers to receive *News Briefs* (currently a weekly fax) via:  Fax  Email

My program prefers to receive *Alerts* (currently sent via fax as needed) via:  Fax  Email

**Do not** list this program in the NHPCO Membership Directory or the “Find a Provider” section of NHPCO’s Web site.

**Everything stated in this form is correct and complete to the best of my knowledge.**

Signature/Title of person completing this form

Please Print Your Name

Date

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