



2004 PROVIDER ACTIVATION FORM

Primary Contact* _____ **Title** _____

Company _____

Address _____

City _____ **State** _____ **Zip** _____

**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.*

Our Corporate Office Information:

Company Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Website _____

2004 Provider Dues – NHPCO Provider dues are based on the number of new hospice patients admitted in the previous calendar year (January 1 to December 31, 2003) for *all hospice multiple locations affiliated with the primary location**, regardless of reimbursement. (Note: Each program’s patient total information will remain confidential and will not be disclosed in any form.) **Minimum Dues are \$200 per year.**

2004 Dues Formula A (Less than 2,500 patients):

- A. Total number of new patients admitted in 2003: _____
- B. Assessment per patient: \$7.00 _____
- C. Multiply patients x \$7.00 to calculate your dues (A x B = C): _____
- D. Minimum Dues are \$200 per year. If line C is less than \$200, please pay minimum dues.

Dues Formula B (2,501-5,000 patients):

- A. First 2,500 patients admitted in 2003 x \$7.00 each: \$17,500 _____
- B. Number of patients admitted over 2,500: _____
- C. Assessment per patient over 2,500: \$5.00 _____
- D. Multiply B x C = D: _____
- E. Add the total of A & D to calculate your 2004 dues: _____

Dues Formula C (over 5,000 patients):

- A. First 2,500 patients admitted in 2003 x \$7.00 each: \$17,500 _____
- B. Second 2,500 patients admitted in 2003 x \$5.00 each: \$12,500 _____
- C. Number of patients admitted over 5,000 in 2003: _____
- D. Assessment per patient over 5,000: \$4.00 _____
- E. Multiply C x D = E: _____
- F. Add the total of A, B & E to calculate your 2004 dues: _____

* NHPCO defines Hospice Multiple Locations as additional hospice service sites under one corporation. The Multiple Locations of Provider members receive many membership mailings and discounts. All mailings for Multiple Locations will be sent to the designated primary contact at the Multiple Location.

Optional “Material Safety Data Sheets” (MSDS) Program:

Participation in the MSDS program is voluntary, however, OSHA requires that health care agencies have on hand for each hazardous chemical or cleaning product they use, a data sheet from the manufacturer that lists the potential hazards and health effects, and describes the measures to take in case of an emergency. NHPCO has negotiated a special group rate for its members through the 3E Company. The annual fee to participate is \$60 for the first location and \$30 for each additional location.

- Yes, I want my hospice(s) to renew/enroll in the MSDS Program.
 - A. First Location \$60
 - B. # of additional locations _____
 - C. \$30 for each additional (B x \$30 = C) _____
 - D. Total (A + C = D) \$_____

Please mail payment with completed forms to NHPCO. Make a copy of all forms for your records prior to mailing. Minimum dues are \$200 per year.

- My check is enclosed in full.
 Check Number _____ Amount \$_____

- I am paying by wire transfer. I understand that **I must return the completed** Provider Activation Form in order for NHPCO to process my payment. Funds were transferred to Account 703025368, Routing Number 061000104, on _____ (date), in the amount of \$ _____. The confirmation number is _____.

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 98% of your dues payment may be tax deductible as an ordinary and necessary business expense. Approximately 2% 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 department at 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, 1700 Diagonal Rd, Suite 625, Alexandria, VA 22314



2004 PROVIDER VERIFICATION FORM

This form is used to report your program's information. Upon joining NHPCO the information will be included in the NHPCO Directory, NHPCO's Web site and used for referral services. Fax the completed form to 703/837-1233, or mail with your Provider Activation Form to NHPCO, Department 929, Alexandria, VA 22334-0929. **Please complete a separate Verification Form for each multiple location.**

Primary Contact	Title	
Company		
Address		
City	State	Zip
Phone	Fax	
E-mail*	Web site	

**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:

Referral Contact:	E-mail:
CNA Coordinator:	E-mail:
Ethics Contact:	E-mail:
Federal Legislative Contact:	E-mail:
Medical Director:	E-mail:
Nursing Staff Director:	E-mail:
Professional Education Contact:	E-mail:
Public Policy Contact:	E-mail:
Standards Contact:	E-mail:

Program Information (please check the appropriate box):

My hospice is: Operating as a Hospice or In the Planning Stages

State Licensed/Accredited as a Hospice (only if your state offers licensure): Yes No

My program has a Certificate of Need (copy attached): Yes No

(The following states require a Certificate of Need: AR, FL, HI, KY, MD, NY, NC, RI, TN, VT, WA, and WV)

Incorporation Status: For-profit Government Non-profit (I have attached the first page from Form 990)

Dominant Ownership Status (choose one):

- | | | |
|---|---|---|
| <input type="checkbox"/> Independent/Freestanding Hospice Corporation | <input type="checkbox"/> Division of Health Plan | <input type="checkbox"/> Division of Hospital |
| <input type="checkbox"/> Division of Home Health Agency | <input type="checkbox"/> Division of Nursing Home | <input type="checkbox"/> Division of Prison |
| <input type="checkbox"/> Division of Veterans Facility | | |
| <input type="checkbox"/> Other (please explain): | | |

2004 PROVIDER VERIFICATION FORM (continued)

Medicare Certified as a Hospice: Yes No

If your program is not Medicare certified, is your hospice a: Volunteer Patient Support Only Inpatient Care Only

Medicaid Certified for Hospice: Yes No

Accredited by: JCAHO CHAP ACHC Other (please specify):

Member of State Hospice Organization: Yes No

Other Services Offered By Your Hospice:

Do you have a Pediatric Palliative Care Program? Yes No

Do you have a service delivery program outside of the model of the Medicare Hospice Benefit?

Yes No (skip table below) Planning Stages

In the table below, please check the type of program(s) you operated or were planning in 2003. Please provide the number of patients/families admitted to the program in 2003.

<u>Program Type</u>	<u>Active Program (check)</u>	<u>Planning Program (check)</u>	<u>2003 Admissions (number of patients/families)</u>
Palliative consult team			
Home Health agency serving primarily terminally ill patients			
Pre-hospice support program			
Post-hospice support program for patients discharged alive			
Grief Counseling for non-hospice families			
Community Bereavement Program			
Hospice-Dedicated Inpatient Facility or Unit			
Other			
Other			

Statistical Information:

Average Daily Census:

<10 10-25 26-50 51-100 101-200 201-350
 351-500 501-650 651-800 801-999 >1,000

Budget Size of Hospice:

<\$250,000 \$250,000-499,999 \$500,000-999,999 \$1-3.9 Mil \$4-6.9 Mil
 \$7-9.9 Mil \$10-14.9 Mil \$15-19.9 Mil \$20-24.9 Mil \$25-29.9 Mil >\$30 Mil

The following information is for research purposes only:

Average Length of Stay (in days) _____ *Median Length of Stay (in days)* _____

Total Paid Staff _____ *Total Full Time Staff Equivalents* _____ *Total Volunteers* _____

2004 PROVIDER VERIFICATION FORM (continued)

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 hospice locale:

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

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.

Yes, my program operates a hospice-dedicated facility/unit consisting of one or more beds, which are owned or leased by my hospice, staffed by my hospice staff and has major policies/procedures set by my hospice. *If Yes, Complete the Facility/Unit Form that follows.*

No, my program does not operate a hospice-dedicated facility/unit. (The answer is No if you have contractual arrangements with other facilities in which the other facility provides basic staff and services while the hospice team visits to establish and oversee the plan of care.) *If No, you do not need to complete the facility information on the next page. However, please sign the form and return all pages with your dues payment.*



2004 PROVIDER FACILITY/UNITS FORM
Please copy and complete this form as needed.

If, on the Program Verification Form you answered, "Yes, my program operates a hospice-dedicated facility/unit," please complete this form. Please fill out a separate form for each facility/unit you operate.

Name of Hospice _____

Hospice Facility/Unit Name _____

Address _____

City _____

State _____

Zip _____

Phone _____

Fax _____

Primary Contact _____

Title _____

Medical Director _____

What is the total number of beds in the facility/unit named above? _____

Where is the facility located? (Check One)

Freestanding Hospice

Hospital (please list name of hospital):

Nursing Home (please list name of nursing home):

Other (please specify):

What level of hospice care does this facility/unit provide predominantly?

Acute/General Inpatient - short-term, intensive hospice services provided in an appropriately licensed or certified skilled nursing facility, hospital, or hospice facility to meet the patient's need for skilled nursing, symptom management, or complex care.

Residential Care - hospice home care provided in a nursing or hospice facility rather than in the patient's personal residence.

Mixed Use - both acute and residential levels.

What was the number of unduplicated patient admissions to the facility/unit in 2003? _____

What was the total number of patient days in this facility/unit in 2003? _____

Do Not list this facility/unit in the NHPCO Membership Directory or on the NHPCO 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 _____