



Section A. Contact Information

Primary Contact*: _____ Title: _____

Company: _____

Address: _____

City, ST ZIP _____

Phone: _____ Fax: _____

Email: _____

Please affirm, by checking here, that your organization is a State Hospice and/or Palliative Care Organization that subscribes to the mission, vision and standards of NHPCO, represents a majority of the current NHPCO Provider Members of the State, and has at least three (3) NHPCO Provider Members. For purposes of these Bylaws, the District of Columbia, American Samoa, Guam and Puerto Rico shall be deemed to be States.

Section B. Membership Dues (January 1, 2010 – December 31, 2010)

2010 Membership Dues: \$ 1,000.00

NOTE: NHPCO dues are reduced by 50% (\$500 minimum) if your State Organization has 90% of any of the following:

- 90% of state members are NHPCO members**
- 90% of state members participate in the national data set
- 90% of state members participate in the FEHC
- 90% of state members who are NHPCO members participate as NHPCO quality partners

**If your State Organization has 100% joint membership, you will receive one complimentary registration for each of NHPCO's annual conferences.

Total Amount Due for 2010 Membership Dues & Optional Services: \$ _____

Section C. Payment Instructions

Please mail payment with completed forms to NHPCO. Make a copy of all forms for your records prior to mailing. Federal Tax ID 541096334.

Please return all forms with payment to: NHPCO, P.O. Box 34929, Alexandria, VA 22334-0929.

For overnight or express delivery forward to: NHPCO, 1731 King Street, Alexandria, VA 22314. Or fax to: 703/837-1233

<input type="checkbox"/> My check is enclosed in full. Check #: _____ Amount Included \$ _____ <input type="checkbox"/> Please charge my: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express Credit Card # _____ Exp Date _____ Name on Card _____ Signature _____	<p>(Office Use Only)</p> Batch # _____ ID # _____ CC Auth Code _____
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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: _____



Section A-1. State Hospice Organization Information

State Hospice Organization: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Email: _____ Web site: _____
 Do not list this organization in the NHPCO Membership Directory.

Section A-2. Primary Contact Information

Primary Contact*: _____ Title: _____
 Company: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Email**: _____
 1. Is this an elected position? Yes No
 1a. If yes, when does the term expire? _____
 2. Is this person eligible to be re-elected? Yes No

Section A-3. Secondary Contact Information

Secondary Contact***: _____ Title: _____
 Company: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Email**: _____
 1. Is this an elected position? Yes No
 1a. If yes, when does the term expire? _____
 2. Is this person eligible to be re-elected? Yes No

Section B. State Information

1. Does your state have licensure laws for hospices? Yes No
 1a. If yes, does your state require that hospices be licensed? Yes No
2. Does your state offer a Medicaid Hospice Benefit? Yes No
3. Does your state require that hospices have a Certificate of Need? Yes No

* Person who will receive all Membership mailings from NHPCO, be listed as the as the primary contact in the Membership Directory, serve as Voting Delegate for matters put to the NHPCO Voting Membership.

** 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 information from NHPCO and its affiliates; membership related notices and benefits; as well as NHPCO related services, such as conference information and Marketplace product announcements and sales.

*** Person will receive Council of States communications if applicable, all NHPCO communications but is not a voting member under the state organization.



Organizational Information

Please read and complete this form thoroughly. In order to be considered for Council of States, you must submit all requested documents and signatures must be provided with your completed application.

1. Please affirm, by checking here, that you have read and that your organization will subscribe to the operating procedures and policies of the COS, which govern its meetings and activities (currently posted on NHPCO's Web site).
2. Please affirm, by checking here, that your organization subscribes to the NHPCO Bylaws, the mission, vision and standards of NHPCO.
3. At what time of year are your elections held? _____
4. Please affirm, by checking here, that you will send updates to NHPCO regarding the election of officers within 30 days of your elections.
5. Are you a NHPCO Quality Partner? Yes No
6. How many full-time staff do you have? _____
6.a. How many full-time staff are allocated for hospice and end-of-life care? _____
7. Please describe your dues structure.

8. Please indicate the dates for your educational events in 2010 and 2011. _____
8.a. Expected number of participants at these events. _____
9. Please affirm, by checking here, that your representatives have agreed to accept the responsibilities as outlined in the operating policies of the COS. The signatures from the two representatives named in this application are required. Alternatively, each representative may send an email to dbales@nhpco.org indicating that they accept this responsibility.

Signature – Primary Contact

Signature – Secondary Contact

Membership dues are non-refundable. Please note that 96% of your dues payment may be tax deductible as an ordinary and necessary business expense. Approximately 4% of your membership dues payment will go towards lobbying efforts and is not tax deductible. This information is not intended as tax advice. Please contact your tax professional for tax advice.

**In order to be considered and approved for COS membership,
the following documents must be included with the submission of your application:**

- Your organization's mission statement. (Note: membership in NHPCO's Council of States requires that your organization have a primary mission statement in support of hospice and end-of-life care.)**
Each COS member must subscribe to NHPCO Bylaws, the mission, vision and standards of NHPCO, represent a majority of the current NHPCO Provider Members of the State, and have at least three (3) NHPCO Provider Members as members of the organization.
- Your annual report** (and/or other documentation that demonstrates the primary mission and focus of your organization.)
- List of Board of Directors (full contact information)**
- Evidence of current Directors and Officers Insurance**
- A copy of your IRS Form 990, for the previous fiscal year**
- A copy of your Bylaws**
- A list of current hospice and palliative care members of your organization and a key contact person for each provider member**

Please return this application with payment to:

NHPCO, P.O. Box 34929, Alexandria, VA 22334-0929 or fax to: 703/837-1233

Please allow up to two weeks for processing. Questions? Call NHPCO's Member Service Center at 800/646-6460.