Palliative Care Individual Member Application

CONTACT INFORMATION

Name: ____________________________________________________________

Title: ____________________________________________________________

Address: □ Home □ Work ____________________________________________

City: _____________________________________________________________________________________________

State: ___________ Zip: ___________

Phone: __________________ Email: __________________

Higest Degree: ____________________________________________________

If you are a physician or APRN, please identify your specialty:

□ Anesthesiology □ Critical Care Medicine □ Family Medicine
□ Geriatric Medicine □ Hematology □ Hospice and Palliative Medicine
□ Internal Medicine □ Medical Oncology □ Nephrology
□ Pain Medicine □ Pediatrics □ Psychiatry
□ Pulmonary Disease □ Radiation Oncology □ Other: ____________________________

PROGRAM INFORMATION

Organization Name: ________________________________________________

Mailing Address (if different from above) ______________________________________

City: _____________________________________________________________________________________________

State: ___________ Zip: ___________

Phone: __________________ Email: __________________

Geographic area served by this location
(Choose one)
□ Primarily Urban □ Primarily Rural □ Mixed Urban and Rural

Predominant Ownership (Choose one)
□ Independent □ Corporate chain □ Health Plan/Managed care/HMO
□ Integrated healthcare system (including VA) □ Continuing care retirement community
□ Correctional facility □ Medicare certified home care agency □ University/academic institution
□ Other (Explain): _____________________________

Do you have a specialized pediatric program: □ Yes □ No

Note: A pediatric palliative care program is a formal pediatric hospice and/or palliative care program that has dedicated staff with expertise in pediatric palliative care for the.

Where are your palliative care services provided? (check all that apply)
□ Home (patient’s residence) □ Clinic
□ Inpatient facility/hospital □ Skilled nursing facility/nursing home
□ Assisted Living Facility

What are your palliative care program’s reimbursement sources? (Check all that apply)
□ Fee-for-service billing □ Medicare Home Health Care Benefit
□ Contracts with payers □ Arrangements with ACOs (Accountable Care Organizations) or MSSPs (Medicare Shared Savings Plans)
□ Private-Pay □ Philanthropy □ Parent Corporation

How many years has your palliative care program been in operation?
□ < 1 year □ 1-2 years □ 3-5 years □ > 5 years

Approximately how many unique patients did you serve in your palliative care program/s during the past calendar year? _____________
**DUES AND OPTIONAL SUBSCRIPTION**

**Physician Membership Dues** (Choose only one; insert $249.00): $___________

**Non-Physician Membership Dues** (Choose only one; insert $149.00): $___________

**Optional Subscription**

**Journal of Pain and Symptom Management Subscription**, Official Journal of NHPCO and American Academy of Hospice and Palliative Medicine $160.00 (Regular Price $292)

☐ Yes, sign me up for a one-year subscription (12 issues). $___________

**Total Amount Due for Membership Dues & Subscription:** $___________

---

**PAYMENT**

Please mail payment with completed forms to NHPCO. Make a copy of all forms for your records. NHPCO’s Federal Tax ID is 54-1096334.

☐ My check is enclosed in full. Check Number: ___________ Amount $___________ (Made payable to NHPCO)

☐ Please charge my:

  ☐ Visa  ☐ MasterCard  ☐ American Express

  Credit Card #_________________________________________ Exp Date ___________

  Name on Card __________________________________________

  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 96.17% of your dues payment may be tax deductible as an ordinary and necessary business expense. As reported in our 1/29/2018 letter outlining our costs of lobbying, approximately 3.83% of your membership dues supports lobbying efforts and is not tax deductible.

Return all forms with payment to: NHPCO, P.O. Box 824392, Philadelphia PA 19182-4392 or Fax to: 703/837-1233.

For overnight payment: PNC Bank c/o NHPCO, Lockbox Number 824392, Route 38 & East Gate Drive, Moorestown, NJ 08057

Allow up to two weeks for processing.

If you have any questions about this application, please call or email the NHPCO Solutions Center at 800-646-6460 or solutions@nhpco.org.