New Provider Member Application

CONTACT INFORMATION

Primary Contact*:________________________ **Title:** ____________________

Primary Contact Email: ________________________ **Primary Contact Phone:**____________________

Company: ____

❍ **Do NOT list this organization in the NHPCO's online "Find a Provider" feature.**

Address: ____

City: ________________________ **State:** ____________ **Zip:** ____________

Phone:____________________ **Website:** ________________________

**The Primary Contact will receive NHPCO Provider mailings, be listed as the point of contact for membership communications, and serve as the Voting Delegate.*

President/CEO: ________________________ **President/CEO Email:**____________________

Corporate Office *(if different from above)*:________________________ **Phone:** ____________________

Company Name:____

❍ **Do NOT list this organization in the NHPCO's online "Find a Provider" feature.**

Address: ____

City: ________________________ **State:** ____________ **Zip:** ____________

Do you operate additional locations? If your hospice operates more than one site, please complete the additional location form and include it with this application. NHPCO membership rules require all locations of member organizations to join together.

DEMOGRAPHICS

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): ____________________
____

Tax Status. If government-owned and not-for-profit, select 'Government' *(Choose one)*

❍ Non-profit
❍ For-profit
❍ Government

Do you have a specialized pediatric program:

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.

❍ Yes
❍ No

Medicare Certified as a Hospice

❍ Yes
❍ No

If no, are you seeking Medicare certification?

❍ Yes
❍ No

Agency Type
(*Select one, based on Medicare filing status)*

❍ Free Standing
❍ Hospital Based
❍ Home Health Based
❍ Nursing Home Based

Accreditations *(select all that apply)*

❍ Accreditation Commission for Health Care (ACHC)
❍ Community Health Accreditation Program (CHAP)
❍ Joint Commission
❍ Other: ____________________
____
❍ Not Accredited

Do you have a palliative care program?

❍ Yes
❍ No

Does your palliative care program provide care based on the Clinical Practice Guidelines for Quality Palliative Care (3rd edition)?

❍ Yes
❍ No

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

DUES

Dues are based on the number of new and unduplicated hospice admissions during the previous 12 months for all locations affiliated with the primary location listed above. Individual hospice service sites of a corporate entity may not join separately. If your hospice operates more than one site, please complete the additional location form and include it with this application.

Dues Calculation Formula

A. Total number of new patients admitted in the previous 12 months: ________

B. Multiply admissions x $9.75 to calculate dues: $______

(Minimum dues are $500. If calculation is less than $500 enter $500)

C. New Member Application Fee *(required)* **$+500.00**

OPTIONAL SERVICES

❍ **Online Material Safety Data Sheet (MSDS) Program.** Complete the MSDS order form and return it with this application. The annual fee for the first location is $55 and $27.50 for each additional location. If ordering subscriptions for more than one location, use the additional location form to identify the MSDS program contacts at each location.

A. Fee for First Location **$55.00**

B. Additional locations # ____ x $27.50 $______

C. Total MSDS $______

MSDS Contact Name:____**Phone:**________________________________**Email:**____________________________________

MSDS contact information is required if purchasing a subscription for this location. List only one MSDS Contact per location.

❍ Sign me up for a one-year subscription (12 issues) to the Journal of Pain and Symptom Management **$160.00**

❍ Yes, I want to make a Contribution to the National Hospice Foundation, the fundraising affiliate of NHPCO. Your voluntary contribution helps impacts hospice and palliative care nationally and at the bedside. Visit **www.nationalhospicefoundation.org/** for more information. $______

❍ I want to make a Donation to the Hospice Action Network. The Hospice Action Network was founded by NHPCO to bolster our lobbying resources on the issues of greatest concern to members of NHPCO. Visit **www.hospiceactionnetwork.org** for more information. $______

Total *(Dues, Optional Services, and Contributions)* $______

Your organization's membership will begin the date the application is processed by NHPCO and will carry a 12 month term.

PAYMENT

Mail payment with completed forms to NHPCO. Make a copy of all forms for your records. NHPCO's Federal Tax ID is 541096334.

❍ **My check is enclosed in full.** Check Number:_________ Amount $__________ (Made payable to NHPCO)

❍ **Please charge my:** ❑ VISA ❑ MasterCard ❑ American Express

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

CREDIT CARD NUMBER

EXP DATE

Visa/MC Cvv Code
3-digits back right side.

AMEX Cvv Code
4-digits front right s

____

NAME ON CARD (PLEASE PRINT CLEARLY)

____

SIGNATURE DATE

Membership dues are non-refundable.

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.

CODE: PROVNEWDA

Hospice Member Provider Application Additional Location Information

Let us know about the other hospice and palliative care service locations your organization operates. If you would prefer, you may submit a spreadsheet of your additional locations, but be sure it includes all of the information requested below.

You can also add MSDS Subscriptions for added locations using this form. Please add $27.50 per subscription to your MSDSOnline section of the application from.

CONTACT INFORMATION

Location Name: ____________________

Address: ____________________

City: ____________________ **State:** ____________________ **Zip:** ____________________

Phone: ____________________ **Fax:** ____________________

Medicare Provider#: ____________________ **Patients Served at this location last 12 Months:** ____________________

Primary Contact's Name: ____________________

Primary Contact's Phone: ____________________ **Primary Contact's Email:** ____________________

MSDS Contact Name: ____________________

MSDS Contact Phone: ____________________ **MSDS Contact Email:** ____________________

MSDS contact information is required if purchasing a subscription for this location. List only one MSDS Contact per location.

FACILITY INFORMATION

Is this location an inpatient unit or facility?

❍ Yes ❍ No

If you answered yes, answer the following 4 questions. Where is the facility located?

❍ Free Standing
❍ Hospital
❍ Nursing Facility
❍ Other____________________

What level of hospice care is provided in this facility/unit? *(Select all that apply.)*

❍ Acute/General Inpatient *(GIP level of care)*
❍ Residential *(RHC level of care provided in the facility rather than in the patient's personal residence)*
❍ Respite

Total number of beds in the facility/unit:

____

Is routine home care also provided from this inpatient unit/facility? *(i.e., does staff provide care in patients' homes from the same location as the inpatient unit/ facility?)*

❍ Yes
❍ No

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Address: ____________________

City: ____________________ **State:** ____________________ **Zip:** ____________________

Phone: ____________________ **Fax:** ____________________

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Primary Contact's Name: ____________________

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