National Hospice and Palliative Care Organization

Associate Membership Application

Associate members are organizations that supply goods or services to hospice and/or palliative care programs and professionals, or those who are supportive of hospice and palliative care such as a hospice foundation, home health agency or grief/bereavement program. Associate membership is not available to organizations that are reimbursed for hospice care or that qualify for another category of NHPCO membership. Organizations serving patients must apply for Provider membership.

GENERAL INFORMATION

Company _____

Address _____

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

Email _____ **Website** _____

Primary Contact _____ **Title** _____

Primary Contact Email _____ **Primary Contact Phone** _____

❍ **On occasion, NHPCO makes its membership list available to hospice-oriented vendors and educators. Please check here if NHPCO should not release your name to such vendors.**

Please provide us with a brief description of your company *(20 to 50 words)*: _____

_____

_____

_____

Please indicate your primary type of business *(please check only one box)*

❍ Accreditation
❍ Assisted Living
❍ Companion Service
❍ Consultant
❍ Disease Management Organization
❍ Durable Medical Equipment
❍ End of Life Care
❍ Foundation
❍ Grief & Bereavement Center
❍ Health Insurance Plan
❍ Home Health Agency
❍ Insurance/Risk Management
❍ International Hospice Program
❍ International Organization
❍ Legal Service
❍ Medical Supply
❍ National Association
❍ Pharmaceutical
❍ Publisher
❍ Religious Organization
❍ Research and Education
❍ Software Vendor
❍ Staffing Agency/Service
❍ Other: _____

MEMBERSHIP TERMS AND PAYMENT

SECTION A - Associate Membership Dues

❍ $1000 Annual Renewal
❍ $500 Discount rate for small organizations with a budget under $500,000

$_____(A)

SECTION B - Additional Subscriptions *(if applicable)*

❍ Journal of Pain and Symptom Management (12 issues/year)… $160

$_____(B)

TOTAL AMOUNT DUE (SUM OF A & B) $ _____

❍ I hereby certify that my organization is not a hospice or palliative care provider, and that everything stated in this form is correct and complete to the best of my knowledge.

NAME OF PERSON COMPLETING FORM (PRINT)

SIGNATURE DATE

❍ **My check is enclosed in full.** Check #_____ $_____
(Made payable to NHPCO)

❍ **Please charge my:** ❑ VISA ❑ MasterCard ❑ Discover

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

Please return form with payment to: NHPCO, P.O. Box 824392, Philadelphia PA 19182-4392 or fax: 703.837.1233. For priority delivery forward to: NHPCO, 1731 King Street, Alexandria, VA 22314 (Please allow up to two weeks for processing) **Questions?** Call NHPCO's Solution Center at (800) 646-6460