National Hospice and Palliative Care Organization

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): ______________________

____

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

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

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

❍ Yes
❍ No

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.

Individual Palliative Care membership is not available to individuals employed by organizations that are reimbursed for hospice care under the Medicare Hospice Benefit. You can learn more about Hospice Provider membership at www.nhpco.org/membership. If you are unsure about your organization's status contact NHPCO's Solutions Center at 800-646-6460 or solutions@nhpco.org.

CODE:
PPCNEWD