National Hospice and Palliative Care Organization

Palliative Care Group Application

CONTACT INFORMATION

Primary Contact*: _____ **Primary Contact Title:** _____

Organization Name: _____

Physical Address: _____

City: _____ **State:** _____ **Zip:** _____

Mailing Address *(if different from physical address)* _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

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

PROGRAM INFORMATION

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? _____

Palliative Care membership is not available to 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: GPCNEWD

PARTICIPATING STAFF

All staff of NHPCO Palliative Care Provider Members is eligible to receive member benefits. List your team members below to ensure they can take advantage of your membership.

1. NAME _____
   TITLE _____
   EMAIL _____

2. NAME _____
   TITLE _____
   EMAIL _____

3. NAME _____
   TITLE _____
   EMAIL _____

4. NAME _____
   TITLE _____
   EMAIL _____

5. NAME _____
   TITLE _____
   EMAIL _____

6. NAME _____
   TITLE _____
   EMAIL _____

7. NAME _____
   TITLE _____
   EMAIL _____

8. NAME _____
   TITLE _____
   EMAIL _____

9. NAME _____
   TITLE _____
   EMAIL _____

10. NAME _____
    TITLE _____
    EMAIL _____

Please use additional pages if you have more than 10 staff to include in your membership.

DUES AND OPTIONAL SERVICES

Palliative Care Provider Membership Dues $ 500.00

Palliative Care Providers can add multiple locations to their membership for only $200 per location (Number of multiple locations x $200) $_____

Optional Services

***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). $ _____

Material Safety Data Sheets Program $55.00 (Regular Price $350)

NHPCO has partnered with a company to offer discounted rates for online MSDS forms. Members may purchase a one-year subscription for $55 for the first location and $27.50 for each additional location.

❍ **Yes, I want to enroll in the online MSDS Program.**
$55 for first location + (27.50 x additional locations). $ _____

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

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.