NHPCO
National Hospice and Palliative Care Organization

New Member Provider 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: ______________ **Fax:** ______________ **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.*

Do you operate additional locations? If your hospice operates more than one site, please complete the additional location section on the reverse side, and/or include a list of additional locations 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.

❍ 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 hospice patients admitted during the previous 12 months - for all locations affiliated the organization. Members are expected to include admissions from all hospice locations within their organization when calculating dues. Individual hospice service sites of a corporate entity may not join separately.

Dues Calculation Formula

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

B. MEMBERSHIP DUES
Multiply admissions x $10.00 to calculate dues: $______
(**MINIMUM DUES ARE $600**. *If calculation is less than $600 enter $600)*

OPTIONAL SERVICES

❍ **Online Material Safety Data Sheet (MSDS) Program.** 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 section 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**

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

Your organization's membership will begin the date the application is processed by NHPCO and will need to be renewed 12/31/2022.

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.** (Made payable to NHPCO)

❍ **Amount $**__________

❍ **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.**

ADDITIONAL LOCATION INFORMATION

Let us know about the other hospice and palliative care service locations your organization operates. If you have more than one subsidiary location, please attach a list of all locations. Be sure to include all of the information requested below if attaching additional locations.

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:** __________________

Location Contact Person:__________________

Location Contact's Email:__________________

MSDS Contact Person:__________________

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.

Is this location an inpatient unit or facility? ❍ Yes ❍ No

CODE: PROV2214