PALLIATIVE CARE INDIVIDUAL MEMBER APPLICATION

NHPCO
Leading Person-Centered Care

Contact Information

Name ________________________ **Title** ________________________

Address: ❑ **Home** ❑ **Work** ________________________

City ________________ **State** ________________ **Zip** ________

Phone ________________________ **Fax** ________________________

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.

- ❑ 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)* $_______________

Non-Physician Membership Dues *(Choose only one; insert $149)* $_______________

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 #_________ $_________

(Made payable to NHPCO)

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

CARD NUMBER

EXPIRATION DATE

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

AMEX Cvv Code:
4-digits front right side

NAME ON CARD (PLEASE PRINT CLEARLY)

SIGNATURE DATE

Membership dues are non-refundable. NHPCO Palliative Care Individual Membership only applies to the applicant and is not transferable to others or to an organization.

NOTE: NHPCO Palliative Care Individual Membership IS NOT available to individuals employed by organizations that provide hospice care, that are vendors or that supply services to hospice, or are consultants. You can learn more about the Hospice Provider or the Associate Vendor membership at **www.nhpco.org/membership-overview-and-benefits**. If you are unsure about your organization's status contact NHPCO's Solutions Center at **800-646-6460** or **solutions@nhpco.org**.

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**.

By signing below I affirm that: Everything stated in this form is correct and complete to the best of my knowledge.

SIGNATURE OF PERSON WHO COMPLETED FORM PRINTED NAME DATE

CODE: PPCNEWD