

PALLIATIVE CARE INDIVIDUAL MEMBER APPLICATION

Contact Information

Name _____ Title _____

Address: ☐ Home ☐ Work _____

City _____ State _____ Zip _____

Phone _____ Email _____

Highest Degree _____

If you are a physician or APRN, please identify your specialty:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Hospice and Palliative Medicine | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Critical Care Medicine | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Medical Oncology | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Geriatric Medicine | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Hematology | <input type="checkbox"/> Pain Medicine | <input type="checkbox"/> 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? _____

\$ _____

\$ _____

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)

\$ _____

\$_____

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: ☐  ☐  ☐ 

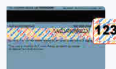
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CARD NUMBER

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EXPIRATION DATE

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Visa/MC Cvv Code:

3-digits back right side

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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.nhpc.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@nhpc.org.

Return all forms with payment to: NHPCO, PO Box 71178, Charlotte, NC 28272-1178 or Fax to: 703-837-1233.

For overnight/express payment: NHPCO, Box 3242, c/o Remitco/Deluxe,
6125 Lakeview Road, Suite 800, Charlotte, NC 28269

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 _____