Indiana Hospice & Palliative Care ORGANIZATION, INC.

2009 HOSPICE PROVIDER MEMBERSHIP APPLICATION

The Provider Membership year runs from January 1st through December 31st.

APPLICANT INFORMATION:

Name of Organization: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: ____________________

Phone: ____________________ Fax: ____________________ Website: ____________________

As a member of IHPCO, I consent to the use of the provided email addresses/fax numbers for receipt of organization notices and newsletters. Please initial __________

Hospice Director: ____________________ Email: ____________________

Hospice Manager: ____________________ Email: ____________________

Referral Contact: ____________________ Email: ____________________

Primary Contact Name: ____________________ Email: ____________________

(Primary Contact person will receive all mailings, etc. from IHPCO and will be listed as the primary contact on the IHPCO website as well as serve as Voting Delegate)

When listing your staff member information, please attach additional sheets as needed.

Medical Director(s): ____________________ Email: ____________________

Patient Care Coordinator(s): ____________________ Email: ____________________

Nurse(s): ____________________ Email: ____________________

Social Worker(s): ____________________ Email: ____________________

Bereavement Counselor(s): ____________________ Email: ____________________

Spiritual Care Counselor(s): ____________________ Email: ____________________

Volunteer Coordinator(s): ____________________ Email: ____________________

Marketing/PR/Development: ____________________ Email: ____________________

Counties Served (identify portion of county with an asterisk (*)): ____________________

____

Is your program: Medicare Certified Hospice? ☐ Yes ☐ No Medicaid Certified Hospice? ☐ Yes ☐ No

JCAHO Accredited? ☐ Yes ☐ No CHAPS Accredited? ☐ Yes ☐ No

Does your program have additional site(s)? ☐ Yes ☐ No

If yes, please list additional sites: (*Please attach additional sheet if necessary)*

Organization: ____________________

Contact Person: ____________________ Email: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: ____________________

Phone: ____________________ Fax: ____________________

Counties this site serves: ____________________

Total Amount Enclosed (from line 6 on reverse) ____________________

Indiana Hospice & Palliative Care ORGANIZATION, INC.

Does your program have:

An inpatient facility? ☐ Yes ☐ No

A palliative care program? ☐ Currently Operating ☐ In Planning Stages ☐ No

What services does this palliative care program provide?

☐ Pediatric Palliative Care ☐ Inpatient Palliative Care Unit
☐ Inpatient Consulting Service ☐ Outpatient

MEMBERSHIP FEES (Please complete a separate membership form for each provider number.)
Please note: If a hospice is owned by a corporation that has multiple locations, all locations in Indiana must join the state organization.

The Indiana Hospice and Palliative Care Organization charges dues based upon a $7.00 per patient, per calendar year fee. Under this definition, “Patient” shall include all patients electing hospice and/or palliative care services over the course of a year (2007), regardless of reimbursement source or license of the program provider. The dues structure shall also include all patients within an organization or healthcare system that may have elected “hospice-like” programs which may be known as “transition programs,” “bridge programs,” “supportive care programs,” “indigent programs,” etc. The dues structure shall also include palliative care patients who may be seen under a home healthcare license, but are receiving palliative care services from the agency and/or organization or healthcare system. To promote an environment of fairness and equity, it is important that all members calculate their dues consistently on this basis. Minimum dues for a program with less than 72 patients is $500.

Line 1 **Total Patients** ______________________________

Line 2 **Total Number of Patients x $7.00*** ______________________________

Line 3 **Number of *Additional* Sites (offices)**______________________________

Line 4 **Special Pain Initiative Provider Membership ($300.00)** ______________________________

Line 4 **Number of Additional Sites x $75.00** ______________________________

Line 5 **Contribution** ______________________________

Line 6 **Total Amount Due** ______________________________

If paying with a credit card, please fill out the following:

Which credit card will be charged? ☐ VISA ☐ MasterCard

Card Number: ____ Expiration Date: _______________

Name Printed on Card: ____

Complete Mailing Address for Credit Card: ____

I authorize the Indiana Hospice & Palliative Care Organization to charge the above credit card for the amount listed on Line 6 above.

Please sign ____

Indiana Hospice and Palliative Care Organization, 3921 N. Meridian St., Suite 225, Indianapolis, IN 46208, 317-464-5145

FOR OFFICE USE ONLY:

Postmarked Date: _______________ **Check Number:** __________________ **Amount: $**_____________________ **Date Received:** ________________