Indiana Hospice & Palliative Care ORGANIZATION, INC.

2018 PROVIDER MEMBERSHIP APPLICATION & RENEWAL

The provider membership year runs from January 1st through December 31st.

Hospice Name: ____

Indiana Counties Served: ____

Hospice Website: ____

Primary Contact Person

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

Email: ______________________ Phone: ______________________

(Primary Contact will receive all mailings, etc. from IHPCO and will serve as Voting Delegate)

Billing Contact Person

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

Email: ______________________ Phone: ______________________

List any additional locations you wish to include on the IHPCO website directory (attach additional pages as necessary).

Address: ____

City: ______________ Zip Code: __________ Phone: ______________

Address: ____

City: ______________ Zip Code: __________ Phone: ______________

Address: ____

City: ______________ Zip Code: __________ Phone: ______________

CONTINUE ON BACK

Who from your organization should receive IHPCO newsletters and notices?

Hospice Director: ____________________________Email: ____________________________________

Hospice Manager: ____________________________Email: ____________________________________

Clinical Contact: _____________________________ Email: ____________________________________

Volunteer Coordinator: ________________________ Email: _____________________________________

Please attach additional names, titles and emails as necessary.

Membership Fees:

Each site licensed by the Indiana State Department of Health should complete a separate application/renewal. The Indiana Hospice and Palliative Care Organization charges dues based upon an $8.00 per patient per calendar year fee. *"Patient" includes all patients served that received hospice and/or palliative care services over the course of the prior calendar year, regardless of reimbursement source or license of the program provider.* The dues structure includes 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. *To promote an environment of fairness and equity, it is important that all members calculate their dues consistently on this basis.*

Line 1:	**Total Patients (total census as of 1/1/17 + total patients in 2017)**	_________________
Line 2:	**Total Number of Patients x $8.00**	**$**_________________
Line 3:	**Number of Additional Sites x $75.00**	**$**_________________
Line 4:	**IHPCO Contribution**	**$**_________________
Line 5:	**Line 2 + Line 3 + Line 4 = Total Amount Due**	**$**_________________

Please return this form with check payable to:

Indiana Hospice and Palliative Care Organization
P.O. Box 68829
Indianapolis, IN 46268-0829

Questions? Call 317-464-5145