Indiana Hospice & Palliative Care
ORGANIZATION, INC.

2025 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: _____

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.* Please note: minimum dues for a program with less than 63 patients is $500.

Line 1: Total Patients (total number of unduplicated admissions) as of 01/01/2024 _____

Line 2: Total Number of Patients x $8.00 **$** _____

Line 3: Number of Additional Sites x $75.00 **$** _____

Line 4: IHPCO Contribution (optional) **$** _____

Line 5: Line 2 + Line 3 + Line 4 = Total Amount Due **$** _____

Signature_____**Title**_____**Date**_____

Please return this form with check payable to:

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

Questions? Call 317-733-2380