HOSPICE & PALLIATIVE CARE
ASSOCIATION OF ARKANSAS
advancing the promise of care

2024 MEMBERSHIP APPLICATION
Hospice Organization/Company

Membership is for the calendar year.

A hospice governing member is a hospice corporation/organization. The organization/company must include all "total patient days" for all locations providing hospice care services in Arkansas on the line designated "total patient days" and each location must be listed on page 4 (use additional pages, if necessary, to add all locations).

_____ _____ _____
Organization/Company Phone # Fax #

_____ _____ _____ _____
Main Office Address City State Zip

_____ _____ _____
Name of Governing (Voting) Member Title Email Address

_____ _____ _____
Name of Contact Person for Application Contact Person's Phone Number Agency Web Address

Hospice Governing Membership:
Note: If your hospice organization owns a palliative care program/service, a separate palliative care application is not required. Please list the palliative care program/service on page 2 with an additional $250 for the palliative care program membership.

Hospice Governing Member
Minimum dues $500 – Maximum dues $14,000

Please indicate total days even if your agency is at the minimum or maximum level.
☐ **Governing** (Licensed Hospice Agency)
Enter Total Patient Days of Service #_____
from December 1, 2022 – November 30, 2023

for **ALL locations serving in Arkansas**: # patient days _____ x .10 = $ _____

Palliative Care Program Add-On - $250
(hospice & palliative care owned by the same company) $_____

Total = $_____

Please complete and mail the entire document (all applicable pages) with a check payable to HPCAA by **January 31, 2024**.

HPCAA * PO Box 242272 * 815 Technology Dr * Little Rock, AR * 72223

INCOMPLETE APPLICATIONS CAN NOT BE PROCESSED
PLEASE ANSWER ALL QUESTIONS – USE ADDITIONAL PAGES IF NEEDED

To serve you better, HPCAA is collecting information that will allow us to build useful distribution lists, make accurate referrals to communities and organizations, and use statistical data when applying for grants/funding to support the mission in Arkansas. The information may also be used when working with regulatory organizations/legislators.

1. **Check the services provided by your agency in addition to hospice services.**

☐ Private/Personal Care ☐ Home Health ☐ Private Duty Nursing

☐ Hospice Inpatient Facility

☐ Palliative Care (Name of Group) _____

Counties Served by Palliative Care _____

Counties Served by Hospice Care _____

Outpatient Palliative Care	☐ Adult	☐ Pediatric
Community/Home base Palliative Care	☐ Adult	☐ Pediatric
Inpatient Palliative Care Consultation	☐ Adult	☐ Pediatric
Inpatient Palliative Care Unit	☐ Adult	☐ Pediatric

2. **Number of hospice employees (all Arkansas locations)**: _____

   a. Number of palliative care employees (Arkansas): _____

3. **Number of volunteer hours (Arkansas locations) Nov 1. 2022 – Oct 31, 2023**: _____

   a. Number of volunteers: _____

4. **Is your agency a member of …**
   National Hospice & Palliative Care Organization Yes _____ No _____
   National Association of Home Care and Hospice Yes _____ No _____
   Center to Advance Palliative Care Yes ____ No _____
   Other memberships? Please specify _____

5. **List names and email addresses, you would like added to the HPCAA general distribution email list (alerts, announcements, newsletters, website login, networking discipline groups – leaders, quality, volunteer leaders, billing, nurse, physician, aides, social work, spiritual care QAPI leaders, educators, managers, supervisors, etc.)**

Please print clearly (Names listed on page 3 will be included)

Name	Title	Email Address

6. Please list and complete information on any <u>inpatient facilities</u> owned and operated by your organization/company in Arkansas. (as applicable). Use additional copies of this page to list all locations if needed.

Facility Name: _____ Contact: _____

Address & City: _____ ☐ Hospice ☐ Palliative Care

County: _____ Phone: _____ # of beds: _____

Facility Name: _____ Contact: _____

Address & City: _____ ☐ Hospice ☐ Palliative Care

County: _____ Phone: _____ # of beds: _____

Facility Name: _____ Contact: _____

Address & City: _____ ☐ Hospice ☐ Palliative Care

County: _____ Phone: _____ # of beds: _____

7. Please list <u>ALL</u> <u>additional locations from which you provide home hospice services in Arkansas</u> (Main Office is already listed on page 1). <u>Use additional copies of this page if needed.</u>

Office Name _____ Telephone _____ Toll-Free_____ Fax _____

Address_____ City _____ State _____ Zip _____

Contact Person _____ Title _____ Email Address _____

REQUIRED - Counties Served by this office _____

Office Name _____ Telephone _____ Toll-Free_____ Fax _____

Address_____ City _____ State _____ Zip _____

Contact Person _____ Title _____ Email Address _____

REQUIRED - Counties Served by this office _____