HOSPICE & PALLIATIVE CARE
ASSOCIATION OF ARKANSAS

2022 MEMBERSHIP APPLICATION
Hospice Organization or Individual

(Individual applicant is not permitted to have direct association with a hospice)
Membership covers January 1 through December 31 annually

Note: Governing membership is by corporation/organization. The corporation/organization must include ALL locations providing hospice service in Arkansas in the "total patient days" line and each location must be listed on page 4 (use additional pages if necessary, to add all locations). Organizations may not submit for partial locations or include out of state locations under their member benefits.

Provider or Individuals Name (Company Name if Multiple Sites)	Phone #	Toll-Free #	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

Please checkmark type of membership:
Note: If your hospice organization owns a palliative care group/service a separate palliative care application is not required (see additional fee below). Please list the palliative care group/service on page 2.

Governing / Minimum dues $500 – Maximum dues $7,000
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 November 1, 2020 – October 31, 2021
for **ALL locations serving in Arkansas** _____
(*Note: Information is not shared with HPCAA Board Members or other hospice providers*) X .08

Palliative Care Program Add-On - $100
(hospice & palliative care owned by the same company) $ _____

Total = $ _____

☐ **Individual** (Individuals not affiliated with a licensed hospice agency) **$50.00**
(Membership does not include voting privileges) (Only complete page one of application)

Please complete and mail entire document (all applicable pages) with check payable to HPCAA by **January 10, 2022**.

411 S Victory St, Suite 205, Little Rock Arkansas 72201
Phone: 501-375-1300 · Fax: 501-375-1375 · www.hpcaa.org

HOSPICE & PALLIATIVE CARE
ASSOCIATION OF ARKANSAS

Hospice Organization Membership – MUST Complete ALL Sections

2022 MEMBERSHIP APPLICATION

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

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

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 _____

Outpatient Palliative Care	■ Adult	■ Pediatric
Community/Homebase 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, 2020 – Oct 31, 2021: _____
   a. Number of volunteers: _____

4. Is your agency a member of NHPCO? _____
   National Hospice & Palliative Care Organization

5. List names and email addresses, you would like added to the HPCAA general distribution email list (alerts, announcements, newsletters, website login, etc.).
   Please include QAPI, Educators and managers/supervisors.
   Please print clearly (Names listed on page 3 will be included)

Name	Title	Email Address

HOSPICE & PALLIATIVE CARE
ASSOCIATION OF ARKANSAS

Hospice Organization Membership – MUST Complete ALL Sections

2022 MEMBERSHIP APPLICATION

6. Please list complete information for the agency inpatient facilities (as applicable). Use additional copies of this page to list all locations, as 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 **ALL locations which you provide hospice home services in Arkansas**, including Main Office (listed on page 1). Use additional copies of this page, as needed.

Office Name	Telephone	Toll-Free	Fax
Address	City	State	Zip
Contact Person	Title	Email Address	

REQUIRED - Counties Served by this office - Please indicate what portion if not entire

Office Name	Telephone	Toll-Free	Fax
Address	City	State	Zip
Contact Person	Title	Email Address	

REQUIRED - Counties Served by this office - Please indicate what portion if not entire