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

2024 MEMBERSHIP APPLICATION
Palliative Care Provider

Membership is for the calendar year.

Palliative Care Program Name _____ Phone # _____ Fax # _____

Address _____ City _____ State _____ Zip _____

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

Name of affiliated hospital, hospice, etc. _____ Agency Web Address _____

Name of Contact Person for Application _____ Contact Phone Number _____

Contact Email Address for Application (if different from above) _____

Palliative care programs owned by a HPCAA member hospice organization are not required to complete a separate palliative care membership.

Palliative Care Governing Membership:

☐ **Governing** (Palliative Care Program/Department/Organization) $300

Governing Member
Please check all the services provided.
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

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

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

Please list all contacts from your palliative care program you would like to add to the HPCAA general distribution list (alerts, announcements, newsletters, etc.).

Name	Title	Email Address