December 1, 2019

Dear Administrator,

It's time to look to 2020! HPCAA continues our work throughout the state and nationally to educate, advocate and improve access to quality hospice and palliative care. We've seen definite growth in Arkansas with providers and community becoming more aware of and interested in the services you offer!

With 2020 approaching, it is time to submit HPCAA Membership Application and Dues.

Governing Membership includes, but is not limited to:

- ✓ Savings of ~40% on every webinar registration (over 40 educational webinars offered annually)
- ✓ Savings of ~30% for every HPCAA conference registrant
- ✓ Free resources and tools via the HPCAA Members Only Webpage
- ✓ Complimentary listing on the HPCAA Website and inclusion in the community online directory
- ✓ Monthly and urgent e-communications with regulatory and legislative updates, including the HPCAA Newsletter and Quality & Compliance News publications
- ✓ A voice with AR Medicaid, Palmetto GBA, state and federal legislators, and state and national associations and provider organizations
- ✓ Opportunities to connect with other professionals in the end of life community
- ✓ Special invitations to community events hosted by HPCAA such as the annual Governor's Proclamation
- ✓ Ability to serve on your state association's committees and Board of Directors

HPCAA is excited to share we are welcoming a new Executive Director in 2020!
We look forward to the opportunities and growth this will bring.
The new Executive Director plans to visit all member locations to get to know your organization!

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

2020 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, 2018 – October 31, 2019 ______________________
for **ALL locations serving in Arkansas** X .08
(*Note: Information is not shared with HPCAA Board Members or other hospice providers*)

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 privilege) (Only complete page one of application)

Please complete and mail entire document (all applicable pages) with check payable to HPCAA or enter online at www.hpcaa.org by **January 10, 2020**.

Hospice Organization Membership – MUST Complete ALL Sections

2020 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, 2018 – Oct 31, 2019: ____________
   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 Organization Membership – MUST Complete ALL Sections

2020 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