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**2025 MEMBERSHIP APPLICATION**

**Hospice Provider**

**Membership is for the calendar year**.

A governing membership is made up of a corporation/organization. The corporation/organization 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 5 (use additional pages, if necessary, to add all locations).

|  |  |
| --- | --- |
| **Organization/Company:**  Click or tap here to enter text. | **Main Office Address:**  Click or tap here to enter text. |
| **Phone #:** Click or tap here to enter text.  **Toll-free #:** Click or tap here to enter text. | **Fax #:** Click or tap here to enter text.  **Organization web address:**  Click or tap here to enter text. |
| **Name/Title of Governing (Voting) Member:**  Click or tap here to enter text. | **Governing Member Phone Number / Email Address:**  Click or tap here to enter text. |
| **Contact Person for Application:**  Click or tap here to enter text. | **Contact Person’s Phone Number / Email Address:**  Click or tap here to enter text. |

**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.

***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: # **Click or tap here to enter text.**

(from December 1, 2023 – November 30, 2024)

for **ALL locations serving in Arkansas**:

# patient days **Click or tap here to enter text.** x .10 = **$ Click or tap here to enter text.**

**Palliative Care Program Add-On - $250**    
 (hospice & palliative care owned by the same company) **$ Click or tap here to enter text.**

**Hospice & Palliative Care Directory Advertising** (see Membership Guide for additional details)

Full Page ($950)1/2 page ($650)1/4 page ($350) **$ Click or tap here to enter text.**

**Total = $ Click or tap here to enter text.**

**Please complete and return the entire document (all applicable pages) with a check payable to HPCAA.**

**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 organization in addition to hospice services.**

Private/Personal Care    Home Health    Private Duty Nursing

Hospice Inpatient Facility (Please complete additional information on page 4.)    
   
 Palliative Care (Name of Group:) Click or tap here to enter text.

Counties Served by Palliative Care: Click or tap here to enter text.

Counties Served by Hospice Care: Click or tap here to enter text.

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**): Click or tap here to enter text.

**Number of palliative care employees** (Arkansas): Click or tap here to enter text.

**3. Number of volunteer hours (Arkansas locations):** Click or tap here to enter text.

**(Nov 1. 2023 – Oct 31, 2024**)

**Number of volunteers**: Click or tap here to enter text.

**4. Is your organization a member of the National Alliance for Care at Home?**     Yes  No

**Is your organization a member of the Center to Advance Palliative Care?**  Yes  No

**Is your organization a member of any other professional organizations?**  Yes  No

If yes, please list: Click or tap here to enter text.

**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)

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| --- | --- | --- |
| **Name** | **Title** | **Email Address** |
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**6. Please list complete information for your organization’s inpatient facilities (as applicable).**

**Use additional copies of this page, if needed.**

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| **Facility Name:**  Click or tap here to enter text. | **Address:**  Click or tap here to enter text. |
| **Phone #:** Click or tap here to enter text.  **Toll-free #:** Click or tap here to enter text. | **Fax #:** Click or tap here to enter text. |
| **Contact Name/Title:**  Click or tap here to enter text. | **Contact Email Address:**  Click or tap here to enter text. |
| **County:**  Click or tap here to enter text. | **# of beds:** Click or tap here to enter text.  **Hospice Care Palliative Care** |

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| **Facility Name:**  Click or tap here to enter text. | **Address:**  Click or tap here to enter text. |
| **Phone #:** Click or tap here to enter text.  **Toll-free #:** Click or tap here to enter text. | **Fax #:** Click or tap here to enter text. |
| **Contact Name/Title:**  Click or tap here to enter text. | **Contact Email Address:**  Click or tap here to enter text. |
| **County:**  Click or tap here to enter text. | **# of beds:** Click or tap here to enter text.  **Hospice Care Palliative Care** |

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| **Phone #:** Click or tap here to enter text.  **Toll-free #:** Click or tap here to enter text. | **Fax #:** Click or tap here to enter text. |
| **Contact Name/Title:**  Click or tap here to enter text. | **Contact Email Address:**  Click or tap here to enter text. |
| **County:**  Click or tap here to enter text. | **# of beds:** Click or tap here to enter text.  **Hospice Care Palliative Care** |

**7. Please list ALL additional locations that you provide hospice home services in Arkansas**

**(Main Office is already listed on page 1). Use additional copies of this page, if needed.**

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| **Office Name:**  Click or tap here to enter text. | **Address:**  Click or tap here to enter text. |
| **Phone #:** Click or tap here to enter text.  **Toll-free #:** Click or tap here to enter text. | **Fax #:** Click or tap here to enter text. |
| **Contact Name/Title:**  Click or tap here to enter text. | **Contact Email Address:**  Click or tap here to enter text. |
| **REQUIRED – Counties served by this office:**  Click or tap here to enter text. | |

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| **Phone #:** Click or tap here to enter text.  **Toll-free #:** Click or tap here to enter text. | **Fax #:** Click or tap here to enter text. |
| **Contact Name/Title:**  Click or tap here to enter text. | **Contact Email Address:**  Click or tap here to enter text. |
| **REQUIRED – Counties served by this office:**  Click or tap here to enter text. | |

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| **Phone #:** Click or tap here to enter text.  **Toll-free #:** Click or tap here to enter text. | **Fax #:** Click or tap here to enter text. |
| **Contact Name/Title:**  Click or tap here to enter text. | **Contact Email Address:**  Click or tap here to enter text. |
| **REQUIRED – Counties served by this office:**  Click or tap here to enter text. | |