A close up of a logo

Description automatically generated

**2025 MEMBERSHIP APPLICATION**

**Palliative Care Provider**

**Membership is for the calendar year.**

|  |  |
| --- | --- |
| **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 of affiliated hospital, hospice, etc.:**  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. |

**NOTE:** Palliative care programs owned by a HPCAA member hospice organization are not required to complete a separate palliative care membership application. Complete the Palliative Care Program Add-on on the Hospice Provider application.

**Palliative Care Governing Membership:**

**Governing** (Palliative Care Provider) **$ 300**

**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 check payable to HPCAA.

Hospice & Palliative Care Association of Arkansas

P.O. Box 242272

Little Rock, Arkansas 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 palliative care services provided by your organization.**

Outpatient Palliative Care  Adult  Pediatric

Community/Home-based Palliative Care  Adult  Pediatric

Inpatient Palliative Care Consultation  Adult  Pediatric

Inpatient Palliative Care Unit  Adult  Pediatric

Counties Served by your palliative care program: Click or tap here to enter text.

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

Check all disciplines within your program:

M.D./D.O.

APP

RN

SW

Chaplain

Other: Click or tap here to enter text.

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

**Is your organization a member of the National Alliance for Care at Home?**  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.

**4. 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.)**

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Email Address** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**5. Please list ALL additional locations that you provide palliative care services in Arkansas**

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

|  |  |
| --- | --- |
| **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. | |

|  |  |
| --- | --- |
| **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. | |

|  |  |
| --- | --- |
| **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. | |