



P.O. Box 6429 • River Forest, IL 60305-6429 • 888-844-7706 • Fax: 888-844-7697 • info@il-hpco.org • www.il-hpco.org

**Name of Organization:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City/State/Zip:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Website:** www. \_\_\_\_\_

List counties you serve which will be used for our Consumer Hospice Locator on www.il-hpco.org (identify a portion of a county with an asterisk\*):  
 \_\_\_\_\_  
 \_\_\_\_\_

As a member of IL-HPCO, I consent to the use of my e-mail address for receipt of organization notices and newsletters. \_\_\_\_\_ (initials).

For others to receive IL-HPCO updates (mailings, e-news, and special announcements) in addition to the contact above, enter staff information here:

Name	Title	Phone Number	Email
	Primary Contact (Voting Delegate)		
	Hospice Director/President		
	Medical Director		
	CFO/Finance Manager		
	Clinical VP/Manager/Director		
	Operations/Purchasing Manager		
	Marketing/PR/Development		
	Compliance Officer		
	Patient Care Coordinator		
	Social Work Coordinator		
	Bereavement Coordinator		
	Spiritual Care Coordinator		
	Volunteer Coordinator		
	Education Coordinator		
	Legislative Contact Person (LCPs)		
	Grass Root Legislative		
	Other:		
	Other:		

Does your program have an additional location(s)?  Yes  No Total Number of Locations: \_\_\_\_\_ Complete section below for each location.

**INDIVIDUAL LOCATION INFORMATION (Make copies and complete this section for each location.)**  
 This location:  Main Office  Multiple Hospice Location  Workstation  Inpatient ( \_\_\_# beds)  Hospice Residence ( \_\_\_# beds)  
**Contact Information (if different from above):** Name of Organization: \_\_\_\_\_  
 Primary Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
 Counties this site serves: \_\_\_\_\_  
 # of patients served at this location in the past 12 months: \_\_\_\_\_  
 Do you have An Inpatient Facility or Hospice Residence?  Yes  No  
 What services do you provide? Pediatric Inpatient Palliative Care Unit Inpatient Consulting Services Outpatient  
 Do you have a program with local adult day care facilities?  Yes  No  
 Do you have a local Veteran Service Organizations (American Legion, Veterans of Foreign Wars, etc.) program?  Yes  No  
 Do you have a specialized Dementia/Alzheimer's program?  Yes  No  
 This program is:  Medicare Certified  JCAHO Accredited  Medicaid Certified  CHAP Accredited

*CONTINUE ON NEXT PAGE*



**MEMBERSHIP FEES**

- Please complete a separate membership application for each license number.
- **Hospice provider dues** are assessed at \$7 per patient admitted and cared for in your program during the most recent 12 monthperiod. The minimum is \$500.
- For **start-up organizations** (those seeking licensure) and palliative care organizations, the dues are \$200.
- For **volunteer and prison hospice programs** there is a voluntary \$50 donation. Please submit a membership application.
- For **new programs**, again this year we are offering a 25% discount.
- For **hospice programs with one hospice license**, maximum dues are \$9,500.
- **Corporate rate** – for hospice providers with multiple licenses. Dues are assessed at:
  - If a hospice is owned by a corporation that has multiple locations, all locations in Illinois must join the state organization.
  - \$7.00 per patient admitted for the most recent 12 month period up to 1500 patients.
  - For 1500 to 2500 patients, the dues are assessed at \$6 per patient admitted for the most recent 12 month period.
  - For greater than 2500 patient, the dues are assessed at \$5 per patient admitted for the most recent 12 month period to a maximum of \$30,000.
- Please consider an additional contribution to support the work of IL-HPCO, a 501(C) (3) Organization. Through your generous donations, IL-HPCO is able to keep the assessed per patient rate at \$7.

**Hospice Provider Dues (one license):**

# of Patients: \_\_\_\_\_ x \$ 7 = \$ \_\_\_\_\_  
 Contribution \$ \_\_\_\_\_  
 Amount Due (min. \$500 max. \$9,500) \$ \_\_\_\_\_

**Start-up Organization Dues:**

Dues = \$ 200.00  
 Contribution \$ \_\_\_\_\_  
 Amount Due \$ \_\_\_\_\_

**Hospice Provider Dues (multiple licenses):**

# of Patients: \_\_\_\_\_ (up to 1500) x \$ 7 = \$ \_\_\_\_\_  
 # of Patients: \_\_\_\_\_ (1501-2500) x \$ 6 = \$ \_\_\_\_\_  
 # of Patients: \_\_\_\_\_ (>2501) x \$ 5 = \$ \_\_\_\_\_  
 Contribution \$ \_\_\_\_\_  
 Amount Due (max. \$30,000) \$ \_\_\_\_\_

**Volunteer or prison hospice programs Dues:**

Dues = \$ 50.00  
 Contribution \$ \_\_\_\_\_  
 Amount Due \$ \_\_\_\_\_

**Yes, we are a new program this year. My total amount due after 25% discount is:** \$ \_\_\_\_\_

**Method of Payment:** (Please select one)

Check \_\_\_\_\_  American Express  Discover  MasterCard  Visa

**Amount Authorized to Charge:** \$ \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name on Card: (Please Print) \_\_\_\_\_

Billing Address for Card: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

By signing I authorize the Illinois Hospice & Palliative Care Organization to charge the above credit card for the amount listed above.

Authorized Signature: \_\_\_\_\_

**Return this form and payment to:**

Illinois Hospice and Palliative Care c/o Financial Office  
 7044 S. 13th Street  
 Oak Creek, WI 53154-1429

**If you have any questions or comments, please feel free to contact IL-HPCO Membership by phone at 888-844-7706 ext. 115 or by Email to [il-hpco\\_membership@il-hpco.org](mailto:il-hpco_membership@il-hpco.org).**