



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/Presidet		
	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



2009 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:** \$ _____
- Yes, we are paying between October 15, 2009 - November 15, 2009.**
My total amount due after 10% discount is: \$ _____
- Yes, we are paying between November 16, 2009 - December 15, 2009.**
My total amount due after 5% 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.