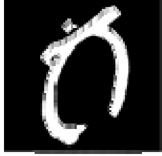

P.O. Box 6429
River Forest, IL 60305-6429
phone: 888-844-7706
fax: 888-844-7697email: info@il-hpco.org
www.il-hpco.org

2008 ILHPCO Hospice Provider Members Application

The Provider Membership year runs from January 1st through December 31st.

Contact Information:

Name of Organization:____

Address:____

City/State/Zip:____

Phone:___________________________ Fax:______________________________

Website:____

Primary Contact:

*Individual who will receive all Provider mailings from ILHPCO and serve as the Voting Delegate.

Name:____
Title:____
Phone:____________________ Email:_________________________________

Please list Counties that you Serve (identify a portion of a county with an asterisk*):

2008 ILHPCO Hospice Provider Members Application (Page 2 of 6)

Staff Information

Some hospice programs want only the primary contact included in mailings and others prefer that information be sent to other contacts. Please check those that should be included with our mailings include name, title, phone number and email addresses.

Hospice Leadership Team (if not listed above):

___Hospice Director/President:

___Medical Director:

___CFO/Finance Manager:

___Clinical VP/Manager/Director:

___Operations/Purchasing Manager:

___Marketing/PR/Development:

___Compliance Officer:

Hospice Services (if not listed above):

___Patient Care Coordinator(s):

___Social Work Coordinator:

___Bereavement Coordinator:

___Spiritual Care Coordinator:

___Volunteer Coordinator:

___Education Coordinator - the person who should receive information on educational programs:

___Legislative Contact Person (LCPs) – the person who will handle grass root legislative action:

___Others not included above:

- ✓ ***Please Check those who should receive updates from ILHPCO***

Please complete this Section, adding additional pages as necessary, for each additional site of your program:

Does your program have an additional site or sites? __Yes __No
(Please complete an additional form for each site.)

Is this site:
___Main Office ___Multiple Hospice Location ___Workstation
___Inpatient Facility
___*Number of Beds*
___Hospice Residence
___*Number of Beds*

Name of Organization: ____

Primary Contact: ____

Email: ____

Address: ____

City: _________________________ State: __________ Zip: ___________

Phone: _______________________ Fax: __________________________

Program Information

- Number of Patients Served at this location in the past 12 months: _____

<u>**2008 ILHPCO Hospice Provider Members Application**</u> **(4 of 6)**

Does your program have An Inpatient Facility or Hospice Residence in the planning stage?
___ Yes*
___ No
*___Number of Beds

Does your program have a Palliative Care Program?
___ Yes*
___ No
** If yes please provide a brief description of your program.*

Does your program have Pediatric Palliative Care?
___ Yes*
___ No
**If yes, please provide a brief description of your program and list the counties that are served by this program.*

Does your program have a program with local adult day care facilities?
___Yes*
___No
**If yes, please provide a brief description of your program.*

Does your program have an established program with local Veteran Service Organizations (i.e. American Legion, Veterans of Foreign Wars, etc.)?
___Yes*
___No
**If yes, please provide a brief description of your program.*

Does your program have a specialized Dementia/Alzheimer's program?
___Yes*
___No
**If yes, please provide a brief description of your program.*

Is your program:

Medicare Certified: ____________JCAHO Accredited: ____________

Medicaid Certified: ____________CHAP Accredited: ____________

2008 MEMBERSHIP FEES:

- **Please complete a separate membership application for each license number.**
- **Hospice provider** dues are assessed at $7.00 per patient admitted and cared for in your program during the most recent 12 month period. This is the same rate that was assessed in 2007. The minimum is $200.00.
- **For start-up organizations (those seeking licensure), and palliative care organizations**, the dues are $200.00.
- **For volunteer and prison hospice programs** there is a voluntary $50.00 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 $9500.00. This is a 6% increase over 2007.
- **Corporate rate** – for hospice providers with multiple licenses. Dues are assessed at:
  - $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 $6.00 per patient admitted for the most recent 12 month period.
  - For greater than 2500 patient, the dues are assessed at $5.00 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 $7.00, the same as 2007.**

Provider Dues:

Total Patients ____________ x $ 7.00 _____________

Contribution _____________

Total Amount Due ________

<u>**2008 ILHPCO Hospice Provider Members Application**</u> **(6 of 6)**

<u>**Payment Instructions**</u>

My Check is enclosed in Full: _____

*Please select method of payment: Visa ____ MasterCard ___ Amex ____

*Credit Card Number: ____

*Expiration Date: _____ *Name on Card: ______________________________

*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. __________________________

*As a member of IL-HPCO, I initial to consent to the use of my e-mail address for receipt of organization notices and newsletters. _______________

If you have any questions or comments please feel free to contact the IL-HPCO office at 888-844-7706 or email at info@IL-HPCO.org. Or check out our website at www.il-hpco.org

Please return this form and payment to:
IL-HPCO
P.O. Box 6429
River Forest, IL 60305-6429

ILHPCO Committee Sign-up Sheet

We need your voice on the following committees. Please list your name, or names of your staff members who would be interested in participating. Please include name, title, phone number and email address.

Nominating/Membership Committee:

Legislative Committee:

Education Committee:

Regulatory/Standards Committee:

Resource Development:

Special Initiatives/Taskforces:

Hospice-Veterans Partnership:

Illinois Pain Initiative:

Children's Project:

If you have any questions or comments please feel free to contact the IL-HPCO office at 888-844-7706 or email at info@IL-HPCO.org.

Please return this form to:
IL-HPCO
P.O. Box 6429
River Forest, IL 60305-6429
Fax: 708/366-2465