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LOUISIANA~MISSISSIPPI
HOSPICE AND PALLIATIVE CARE ORGANIZATION

PROVIDER MEMBERSHIP APPLICATION

Complete pages 1, 2, and 3 of application and return it with your membership dues.

ALL INFORMATION CONTAINED WITHIN WILL BE HELD IN THE STRICTEST CONFIDENCE AND ONLY USED FOR END-OF-LIFE CARE RESEARCH.

Term of membership: January 1 - December 31

The purpose of the Louisiana-Mississippi Hospice and Palliative Care Organization is to foster and promote quality hospice and End-of-life care, as defined by the National Hospice and Palliative Care Organization's Standards and Guidelines, for terminally ill patients and their families. LMHPCO provides a network for the evolution and dissemination of communication, education, legislation, and standards of care related to end-of-life care in Louisiana and Mississippi. Members commit themselves to observance of these standards and support the goals and objectives of LMHPCO.

LMHPCO is a not-for profit, 501 (c) 3 corporation. All donations made to LMHPCO qualify as tax-exempt deductions under the Internal Revenue Code, and are therefore deductible to the fullest extent of the law. As a nonprofit corporation, Louisiana-Mississippi Hospice and Palliative Care Organization, Inc., (sometimes herein referred to as "LMHPCO") is not formed for personal profit. No part of the net income or assets of LMHPCO is distributable to or for the benefit of its Members, its Directors, its Officers, or other private person. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publication or distribution of statements), any political campaign on behalf of or in opposition to any candidate for public office.

Please note: All multiple locations, associated with the same state license/provider number, must be included in membership, as well as all office locations within LA and/or MS, within the same corporation and/or parent company.

☐ **PROVIDER MEMBERSHIP (Complete pages 1, 2, and 3 ONLY.)**

Available to all licensed hospices agencies operating in Louisiana and Mississippi.

Hospice Name _____ Mailing Address _____

Location Address _____ City, State, Zip _____

Contact Person _____ Title _____

Telephone Number _____ FAX Number _____

Toll Free Number _____

Web site Address _____ Office/Staff E-mail Address _____

Name of Voting Member _____ Voting Member's E-mail Address _____

LIST OTHER PHYSICAL OFFICES LOCATIONS (WITH THE SAME PROVIDER NUMBER)

1. Hospice Name _____ Location/Mailing Address _____

Telephone Number / FAX Number _____ City, State, Zip _____

Contact Person _____ E-mail address _____

2. Hospice Name _____ Location/Mailing Address _____

Telephone Number / FAX Number _____ City, State, Zip _____

Contact Person _____ E-mail address _____

PLEASE CONTINUE ON NEXT PAGE

1. Does your agency currently participate or would your agency like to participate in any of the following:
(please place check where appropriate for all below that apply and provide contact information requested)

☐ **LMHPCO Education Committee**

Committee member's name _____ email address _____

☐ **LMHPCO VA Hospice Taskforce**

Taskforce member's name_____ email address _____

☐ **Alliance for the Advancement of End of Life Care (AAEoLC)**

Contact person_____ email address _____

☐ **At Risk Registry**

Contact person_____ email address _____

☐ **We Honor Veterans** ☐ Recruit ☐ Level One ☐ Level Two ☐ Level Three ☐ Level Four

Contact person_____ email address _____

REGARDING VETERANS SERVICES AND SUPPORT

2. Does your agency include the NHPCO/VA recommended Military History check list in its enrollment/initial assessment process?
☐ yes ☐ no

2.b. How many Veterans did your agency care for last year? ☐

2.c. How many referrals did your agency receive for the VA last year? ☐

2.d. Does your agency assign volunteers who served in the military to patients who are veterans? ☐ yes ☐ no

REGARDING BEREAVEMENT SERVICES AND SUPPORT

3. Does your agency offer Bereavement support groups in your community? ☐ yes ☐ no

Support group's location: _____

Day of the week or Dates: _____ Time: _____

Contact person_____ email address _____

3.b. Does your agency offer Bereavement support groups for children? ☐ yes ☐ no

Children's Support group location:_____

Day of the week or Dates: _____ Time: _____

Contact person_____ email address _____

3.c. Does your agency offer Bereavement Camps? ☐ yes ☐ no

Camp location:_____

Dates:_____ Time: _____

Contact person_____ email address _____

REGARDING PEDIATRIC SERVICES AND SUPPORT

4. Does your agency offer pediatric hospice/palliative care in the community? ☐ yes ☐ no

PLEASE CONTINUE ON NEXT PAGE

AFFILIATION:

- ☐ Hospital Administered (owned/operated)
- ☐ Hospital/Home Health (dually licensed)
- ☐ Freestanding
- ☐ In-Patient Hospice Licensed Facility
- ☐ In-Patient Hospice Contract
- ☐ Nursing Home

MEMBERSHIP

- ☐ National Hospice & Palliative Care Organization
- ☐ Hospice Foundation of America
- ☐ National Association of Home Care
- ☐ Other _____

CERTIFICATION/LICENSURE STATUS

- ☐ LA Medicare Certified
- ☐ MS Medicare Certified
- ☐ LA Medicaid Certified
- ☐ MS Medicaid Certified
- ☐ JCAHO Accredited
- ☐ CHAPS Accredited
- ☐ AHCH Accredited

- ☐ For Profit
- ☐ Not for Profit
- ☐ Government owned

Date Opened: _____ Date Licensed: _____ CMS Provider ID: _____

E-MAIL CONTACTS FOR YOUR AGENCY (*designated recipients for weekly & monthly communications from LMHPCO)

	CONTACT NAME	E-MAIL ADDRESS
Medical Director:		
Administrator:		
Office Manager:		
DON/PCC:		
Social Worker:		
Chaplain:		
Volunteer Manger:		
Pharmacist:		
Marketing:		
Educators:		

CALCULATION OF PROVIDER MEMBERSHIP DUES

Members can choose which annual dues option they prefer: The **Corporate Option** or the **Traditional Calculation Option**. Members now have the right to choose which dues option they prefer for their agency: the **Corporate Option** or the **Traditional Calculation Option**.

☐ CORPORATE DUES OPTION *(for multiple locations)*

The Corporate rate is an annual flat fee of $7,600, plus $600 per location.

Dues Formula for Corporate Member:

A. Annual Fee for Corporate Member $7,600.00
B. Additional Physical Locations ($600.00 per location) _____
C. 3.0% Credit Card Surcharge _____
D. **TOTAL** _____

☐ TRADITIONAL DUES OPTION

Annual Provider Membership dues are based on 3 items:

1) **Base fee for the primary office of the provider ($1000)**;
2) **Number of all additional physical locations/offices** associated with the same state license/provider number as the primary office ($400); and
3) **Number of new admissions for the past year (up to a maximum of 500)** under the same provider number ($5 per patient).

Traditional Dues Formula for Provider Member:

A. Annual Fee for Provider Member $1000.00
B. Additional Physical Locations ($400.00 per location) _____
C. Total number of new admits in previous calendar year (Max 500) _____
D. Assessment per Patient $ 5.00
E. Multiply patients x $5.00 to calculate your Dues (CxD=E) _____
F. Total LMHPCO Membership Dues (A+B+E=F) _____
G. 3.0% Credit Card Surcharge _____
H. **TOTAL** _____

Note Regarding the Traditional Dues Option: *Each program's patient total information will remain confidential and will not be disclosed in any form. Each separately State licensed provider agency (with a different provider number) must have a separate LMHPCO Provider Membership under the Traditional Dues Option*

☐ FIRST-TIME PROVIDER MEMBER

dues are $500.00, instead of $800.00, for the first year of operations or during the initial year of the formation of the hospice.

Credit Card Payment Information

Please check: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover Total Charge: $_____

Card # _____ Security Code ___ Exp. Date: _____

Name: (please print)_____

Signature:_____

PLEASE MAIL COMPLETED APPLICATION AND PAYMENT TO:

LMHPCO, 717 Kerlerec • New Orleans, LA 70116
Telephone: (504) 945-2414 • Toll Free: (888) 546-1500 • Fax: (504) 948-3908 • Email: LMHPCO@AOL.com • www.LMHPCO.org