



5 Concourse Parkway, NE, Suite 3000  
Atlanta, GA 30328

*Advancing the art and science of comprehensive hospice, palliative and end-of-life care in Georgia*

Dear GHPCO Member:

We at the Georgia Hospice and Palliative Care Organization want to thank you again for your membership and support over the last year. Membership dues from programs like yours is our largest source of funding, funding that we need to continue our vital work in important areas such as access and quality.

GHPCO actively challenges its members to focus on creating pathways for care at the end of life by increasing access to care, improving the quality of hospice and palliative care services and business practices, and integrating palliative care into the hospice community.

As a GHPCO member, your organization will benefit from:

- Members-only listing in online searchable database for consumer and referral-source use as well as patient referrals via our Referral Helpline
- Members-only access page on the GHPCO website
  - Regulatory resources
  - Reference materials
  - Message/communication board
  - MORE!
- Access to CEU's for your own programs at *no additional cost to you*
- Access to Quality Demonstration Projects, State and National Quality Resources
- Substantial discounts at GHPCO Education Events and Conferences
- Legislative Support and Representation at the State Capitol
- Representation at State and National Events
- Access to Market-specific utilization and demographic data reports and trend analyses
- Members-only discounts for products and services to optimize operations
- Advocacy at Medical Care Advisory Committee to Department of Community Health
- GHPCO Members Newsletter /Hospice News Network Newsletter/Updates and Alerts
- Regional Meetings and Networking Opportunities
- Advocacy and Collaboration with DCH's Healthcare Facilities Regulatory Division
- Technical assistance from subject matter experts in GHPCO

These programs are investments in the future of your work and ours, but we need your continued help to make them possible. **We trust that you will put renewing your GHPCO membership on the top of your priority list, and that you will return the attached Provider Membership Renewal Form as soon as possible.** Should you have any questions about the form, your membership, or if you would like to learn more about what you can do to partner with us, please let us know through our State Executive's office line, 877- 924-6073.

We look forward to your continuing participation in GHPCO throughout the year!

In partnership,

Jennifer Hale, RN BS CHPN  
State Executive



**2010/2011 Provider Membership RENEWAL Application**  
(The Membership year runs from April 1<sup>st</sup> through March 31<sup>st</sup>)

**NOTE: If you are a hospice with multiple locations and are submitting your membership renewal for all locations at once, please complete a copy of this page for EACH additional location and return with your application.**

**Section I: Contact Information.**

Name of Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (PO Box) (City) (State) (Zip Code)

Phone: ( \_\_\_ ) \_\_\_ - \_\_\_ - \_\_\_ Fax: ( \_\_\_ ) \_\_\_ - \_\_\_ - \_\_\_ Website: \_\_\_\_\_

Primary Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_ Email: \_\_\_\_\_

*(Primary Contact person will receive all mailings, etc. from GHPCO and will be listed as the primary contact on the GHPCO website as well as serve as the Voting Delegate at the Annual Conference)*

**Additional Email Contacts for Information (education, clinical, regulatory, etc):**

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Section II: Changes to Organization Information:**

Please document any changes to information submitted previously for accurate reflection in the online database and member records.

Counties served: \_\_\_\_\_

Hospice Facility? Yes No

If yes, please provide the following:

Hospice Facility/Unit Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (PO Box) (City) (State) (Zip Code)

Phone: ( \_\_\_ ) \_\_\_ - \_\_\_ - \_\_\_ Fax: ( \_\_\_ ) \_\_\_ - \_\_\_ - \_\_\_ Website: \_\_\_\_\_

Primary Contact: \_\_\_\_\_ Title: \_\_\_\_\_ Email: \_\_\_\_\_

What is the total number of beds in the facility/unit named above? \_\_\_\_\_

Accredited by:  Not accredited  JCAHO  CHAP  ACHC  Other (please specify): \_\_\_\_\_

Member of NHPCO?:  Yes  No

Member of NAHC?:  Yes  No

Separate Palliative Care Program?  Yes  No

Pediatric Hospice/Palliative Care Program?  Yes  No

**Section III- Membership Fees**

**A. Hospice Providers**

**The Georgia Hospice and Palliative Care Organization charges dues based upon a minimum annual fee of \$250.00 (Basic level) plus \$3.00 per new patient admitted in calendar year 2009, up to a maximum of \$7,500.00.**

**Optional Membership levels available!**

\_\_\_\_\_ **Supporter** = \$500 minimum and \$3 per patient admit in previous calendar year, not prorated, basic membership benefits plus free attendance for up to 5 people at education offering of choice except annual conference

\_\_\_\_\_ **Sponsor** = \$1000 minimum and \$3 per patient admit in previous calendar year, not prorated, basic membership benefits plus free attendance for up to 5 people at education offering of choice except annual conference and named as sponsor of any education event of choice, except annual conference and named as Sponsoring member in brochure of annual conference

\_\_\_\_\_ **Patron** = \$2000 minimum and \$3 per patient admit in previous calendar year, not prorated, basic membership benefits plus free attendance for up to 5 people at education offering of choice except annual conference and named as sponsor of any education event of choice, except annual conference and named as Patron member in brochure of annual conference and named as sponsor of one meal at annual conference

Choose a level of membership then calculate dues based on patient admits for previous calendar year plus membership level

A	Membership Minimum Fee (BASIC LEVEL)	\$250.00
B	Supporter Level	\$500.00
C	Sponsor Level	\$1000.00
D	Patron Level	\$2000.00
E	Total Number of new Patients admitted in calendar year 2009	
F	Per Patient Fee = \$3.00	\$3.00
G	Patient Sub-total = (E x F)	
H	Total Calculated Dues = (Line G + A, B, C, or D)	

Total number of locations covered by this Application: \_\_\_\_\_ (Be sure a copy of Page 1 is attached for each location).

**B. Palliative Care Program Providers**

The Georgia Hospice and Palliative Care Organization charges palliative care program dues of **\$ 250 per year** (no prorated dues are offered). Palliative Care providers receive basic membership benefits.

Everything stated in this form is correct and complete to the best of my knowledge.

Person completing this form: \_\_\_\_\_

(Signature)

(Title)

Please **Print** Your Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(mm) (dd) (yy)

*NOTE: Only Provider members in good standing (i.e. existing, current members who have paid their dues in full) shall be eligible to nominate and vote at the Annual Conference to elect directors to the GHPCO Board. Only rep resentatives from Provider members in good standing shall be elected to serve on the Board ofDirectors of GHPCO.*

**Questions:** Please, feel free to contact the GHPCO office at toll-free 877-924-6073 or email us: [Jennifer@ghpco.org](mailto:Jennifer@ghpco.org)

**PAYMENT**

Please send the:

1. Completed 2010/2011 Provider Membership Application form
2. A copy of your organization's State of Georgia License
3. This Payment form... and
4. P a y m e n t

*TO:*   **Georgia Hospice and Palliative Care Organization**  
**Five Concourse Parkway, NE, Suite 3000**  
**Atlanta, GA 30328**

Payment may be made by check, credit card, or money order. Please make check(s) payable to "GHPCO".

Check \_\_\_\_\_ Check No. \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \_\_\_\_\_ Money Order \_\_\_\_\_

MasterCard \_\_\_\_\_ Visa \_\_\_\_\_ American Express \_\_\_\_\_

Account No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(mm) (yy)

V code (3 digits on back of card) \_\_\_\_\_ Billing zip code: \_\_\_\_\_

Cardholder's Name (Please Print):

**FOR OFFICE USE ONLY:**

Check Number: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Deposited: \_\_\_\_/\_\_\_\_/\_\_\_\_

C r e d i t   C a r d   A p p r o v a l   C o d e :     I n v o i c e   N u m b e r :

Date Transmitted: \_\_\_\_/\_\_\_\_/\_\_\_\_