



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 Potential GHPCO Member:

We at the Georgia Hospice and Palliative Care Organization want to invite you to participate in the only statewide membership organization in Georgia that focuses exclusively on Hospice and Palliative Care providers. 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 joining GHPCO on the top of your priority list, and that you will return the attached Provider Membership Application 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 participation in GHPCO throughout the year!

In partnership,

Jennifer Hale, RN BS CHPN
State Executive



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2010/2011 NEW Provider Membership Application

(The Membership year runs from April 1st through March 31st)

NOTE: If you are a hospice with multiple locations and are submitting your membership 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 - Counties Served: _____

Section III - Hospice Facility/Unit (if applicable)

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? _____

Section IV – Status: (All Hospice providers MUST complete this section)

Is your organization licensed in Georgia? Yes No If Yes, what was the issue date? ____ / ____ / ____
(mm) (dd) (yy)

If “No”, when do you expect to be licensed? _____ In what states? _____

IMPORTANT: A copy of your Georgia license **MUST** be submitted with this application to be processed.

Section V - Program Information - (Palliative Care Providers please go directly to Part B):

A. Hospice Providers Only (please check the appropriate box)

My program is: Operating as a Hospice In the Planning Stages

Incorporation Status: For-profit Government Non-profit

Dominant Ownership Status (choose one):

- | | |
|---|---|
| <input type="checkbox"/> Independent/Freestanding Hospice Corporation | <input type="checkbox"/> Division of Health Plan |
| <input type="checkbox"/> Division of Hospital | <input type="checkbox"/> Division of Home Health Agency |
| <input type="checkbox"/> Division of Nursing Home | <input type="checkbox"/> Division of Prison |
| <input type="checkbox"/> Division of Veterans Facility | |

Other (please explain): _____

Accredited by: JCAHO CHAP ACHC Other (please specify): _____

Member of NHPCO?: Yes No

Member of NAHC?: Yes No

Other Services Offered By Your Hospice:

Do you have a Pediatric Palliative Care Program? Yes No

Do you operate a hospice-dedicated facility/unit consisting of one or more beds, which are owned or leased by the hospice, staffed by the hospice staff and has major policies/procedures set by the hospice?

Yes. Complete the section **Hospice Facility/Unit** below for each Facility/Unit you operate.

No - (The answer is No if you have contractual arrangements with other facilities in which the other facility provides basic staff and services while the hospice team visits to establish and oversee the plan of care.) If **No**, you do not need to complete **Hospice Facility/Unit** below.

Do not list this program in the “*Find a Provider*” section of the GHPCO Web site.

Medicare Certified for Hospice: Yes No

Medicaid Certified for Hospice: Yes No

B. Palliative Care Providers Only:

My Palliative Care Program is:

Currently Operating In the Planning Stages Also operates a Hospice Program

Provides (check all applicable):

Pediatric Palliative Care Inpatient Consultation Service

Inpatient Palliative Care Unit Outpatient

Teaching Service(s): Medical Nursing Social Work Spiritual Care Other

Satellite site: Yes No

Dominant Corporate Status (choose one):

Hospital: Private Non Profit For Profit

Palliative Care Group Practice Hospice Private Practice

Division of Home Health Agency Division of Nursing Home

Division of Prison Division of Veterans Facility Other (HMO,PPO, DME, etc.) _____

Member of NHPCO: Yes No

Do not list this program in the “*Find a Provider*” section of the GHPCO Website.

Section V - 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 representatives from Provider members in good standing shall be elected to serve on the Board of Directors of GHPCO.

Questions:

Please, feel free to contact the GHPCO office at toll-free 877-924-6073 or email us at: 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. Payment

**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): _____

Authorized Signature: _____

FOR OFFICE USE ONLY:

Check Number: _____ Amount: \$ _____ Date Received: ____/____/____

Date Deposited: ____/____/____

Credit Card Approval Code: _____ Invoice Number: _____

Date Transmitted: ____/____/____