



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, 2012

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

1. Does your agency 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 NHPACO/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

AFFILIATION:

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

CERTIFICATION/LICENSURE STATUS

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

MEMBERSHIP

- National Hospice & Palliative Care Organization
- Hospice Foundation of America
- National Association of Home Care
- Other _____
- For Profit
- Not for Profit
- Government owned

Date Opened: _____ Date Licensed: _____

E-MAIL CONTACTS FOR YOUR AGENCY (*monthly e-newsletter, The Journal recipient):

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

Annual Provider Membership dues are based on 3 items:

- 1) **Base fee for the primary office of the provider (\$800);**
- 2) **Number of all additional physical locations/offices associated with** the same state license/provider number as the primary office (\$300); and
- 3) **Number of new admissions for the past year** under the same provider number (\$4 per patient).

First, the base fee is filled in for you.

Second, multiply the number of all physical locations/offices associated with the primary office times \$300.00. All multiple locations, associated with the same state license/provider number, must be include in this calculation.

Third, list the number of all new hospice patients admitted under the same provider number in the previous calendar year, regardless of reimbursement, and multiply times \$4.00, up to a maximum of 500 new admissions per year.

Note: *Each program's patient total information will remain confidential and will not be disclosed in any form. Each separately State licensed provider must have a separate LMHPCO Provider Membership.*

First-time Provider Member dues are \$400.00, instead of \$800.00, for the first year of operations or during the initial year of the formation of the hospice.

Dues Formula for Provider Member:

A.	Annual Fee for Provider Member	\$800.00
B.	Additional Physical Locations (\$300.00 per location)	_____
C.	Total number of new admits in previous calendar year (Max 500)	_____
D.	Assessment per Patient	\$ 4.00
E.	Multiply patients x \$4.00 to calculate your Dues (Cx D=E)	_____
F.	Total LMHPCO Membership Dues (A+B+E=F)	_____

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

www.LMHPCO.org Email: LMHPCO@AOL.com