



# 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, 2018**

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 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 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

**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 (\*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**

In May 2016, the Board of Directors approved a new **Corporate Dues Option** for those hospices with multiple locations in Louisiana and/or Mississippi. 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 \$6,950, plus \$550 per locations.

**Dues Formula for Corporate Member:**

- A. Annual Fee for Corporate Member \$6950.00  
 B. Additional Physical Locations (\$550.00 per location) \_\_\_\_\_  
 C. 2.5% 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 (\$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 (up to a maximum of 500)** under the same provider number (\$4 per patient).

**Traditional 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) \_\_\_\_\_  
 G. 2.5% 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 \$400.00, 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