November 28, 2018

Dear Administrator,

It's hard to believe another year is almost behind us! HPCAA continues our work throughout the state and nationally to educate, advocate and improve access to quality hospice and palliative care. We've seen definite growth in Arkansas with providers and community becoming more aware of and interested in the services you offer!

With 2019 approaching, it is time to submit 2019 HPCAA Membership Application and Dues.

Governing Membership includes, but is not limited to:

- ✓ Savings of ~40% on every webinar registration (over 40 educational webinars offered annually)
- ✓ Savings of ~30% for every HPCAA conference registrant
- ✓ Free resources and tools via the HPCAA Members Only Webpage
- ✓ Complimentary listing on the HPCAA Website and inclusion in the community online directory
- ✓ Monthly and urgent e-communications with regulatory and legislative updates, including the HPCAA Newsletter and Quality & Compliance News publications
- ✓ A voice with AR Medicaid, Palmetto GBA, state and federal legislators, and state and national associations and provider organizations
- ✓ Opportunities to connect with other professionals in the end of life community
- ✓ Special invitations to community events hosted by HPCAA such as the annual Governor's Proclamation
- ✓ Ability to serve on your state association's committees and Board of Directors

Thank you, in advance, for your support to help us ensure that all in need receive the care they deserve when facing a serious illness.

Sincerely,
Lisa Vaden
HPCAA Executive Director

411 S Victory St, Suite 205, Little Rock Arkansas 72201
Phone: 501-375-1300 · Fax: 501-375-1375 · www.hpcaa.org

2019 MEMBERSHIP APPLICATION
Hospice Organization or Individual

(Individual is not permitted to have direct association with a hospice)
Membership covers January 1 through December 31 annually

Note: Governing membership is by corporation/organization. The corporation/organization must include ALL locations providing hospice service in Arkansas in the "total patient days" line and each location must be listed on page 4 (use additional pages if necessary to add all locations). Organizations may not submit for partial locations or include out of state locations under their member benefits.

Provider or Individuals Name (Company Name if Multiple Sites)	Phone #	Toll-Free #	Fax #

Main Office Address	City	State	Zip

Name of Governing (Voting) Member	Title	Email Address

Name of Contact Person for Application	Contact Person's Phone Number	Agency Web Address

Please checkmark type of membership:

Note: If your hospice organization owns a palliative care group/service a separate palliative care application is not required. Please list the palliative care group/service on page 2.

Governing / Minimum dues $500 – Maximum dues $7,000

Please indicate total days even if your agency is at the minimum or maximum level

☐ **Governing** (Licensed Hospice Agency)
Enter Total Patient Days of Service
from November 1, 2017 – October 31, 2018 ______________________
for **ALL locations serving in Arkansas** X .08
(*Note: Information is not shared with HPCAA Board Members or other hospice providers*) **Total = $** ______________________

☐ **Individual** (Individuals not affiliated with a licensed hospice agency) **$50.00**
(Membership does not include voting privilege)
(Only complete page one of application)

Please complete and return entire document (all applicable pages) with check payable to HPCAA by **January 11, 2019**.

Thank you for your support!

Hospice Organization Membership – MUST Complete ALL Sections

2019 MEMBERSHIP APPLICATION

To serve you better, HPCAA is collecting information that will allow us to build useful distribution lists, make accurate referrals to community and organizations, and to use as statistical data when applying for grants/funding. The information may also be used when working with regulators and legislators.

INCOMPLETE APPLICATIONS CANNOT BE PROCESSED
PLEASE ANSWER ALL QUESTIONS – USE ADDITIONAL PAGES IF NEEDED

1. Check the services provided by your agency:
   □ Private/Personal Care □ Home Health □ Private Duty Nursing □ Hospice Inpatient Facility

   □ Palliative Care (Name of Group ____)
   Outpatient Palliative Care □ Adult □ Pediatric
   Inpatient Palliative Care Consultation □ Adult □ Pediatric
   Inpatient Palliative Care Unit □ Adult □ Pediatric

2. Number of employees (all Arkansas locations): ______________________________

3. Number of volunteer hours (Arkansas locations) Nov 1, 2017 – Oct 31, 2018: ______________
   a. Number of volunteers: ______________________________________

4. Is your agency a member of NHPCO? ______________________________________
   National Hospice & Palliative Care Organization

5. List names and email addresses you would like added to the HPCAA general distribution email list (alerts, announcements, newsletters, website login, etc.).
   Please include QAPI, Educators and managers/supervisors.
   Please print clearly (Names listed on page 3 will be included)

Name	Title	Email Address

411 S Victory St, Suite 205, Little Rock Arkansas 72201
Phone: 501-375-1300 · Fax: 501-375-1375 · www.hpcaa.org

Hospice Organization Membership – MUST Complete ALL Sections

2019 MEMBERSHIP APPLICATION

6. Please list complete information for agency inpatient facilities (as applicable). Use additional copies of this page to list all locations, as needed.

Facility Name: ______________________ Contact: ______________
Address: ______________________ □ Hospice □ Palliative Care
County: ____________ Phone: ____________ # of beds: ________

Facility Name: ______________________ Contact: ______________
Address: ______________________ □ Hospice □ Palliative Care
County: ____________ Phone: ____________ # of beds: ________

Facility Name: ______________________ Contact: ______________
Address: ______________________ □ Hospice □ Palliative Care
County: ____________ Phone: ____________ # of beds: ________

7. Please list **ALL locations which you provide hospice home services in Arkansas**, including Main Office (listed on page 1). Use additional copies of this page, as needed.

Office Name	Telephone	Toll-Free	Fax
Address	City	State	Zip
Contact Person	Title	Email Address	

REQUIRED - Counties Served by this office - Please indicate what portion if not entire

Office Name	Telephone	Toll-Free	Fax
Address	City	State	Zip
Contact Person	Title	Email Address	

REQUIRED - Counties Served by this office - Please indicate what portion if not entire