Please verify the information we have

is correct/updated. Payment for dues should be based off the calculation on

the back. This form is required

to be sent in with payment.

HPCAI Provider Membership Application

**The annual membership term begins on January 1st and ends on December 31st. Unpaid dues result in terminated membership beginning April 1.**

**Please review the information below and return with your payment:**

**Current contact information:**

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Administrator or Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Financial Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Services provided: Hospice Hospice Facility or Unit Palliative Care

Last year’s dues paid:

**If your record needs updating, please fill in the correct information below:**

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare Provider #: \_\_\_\_\_ \_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Agency Administrator or Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Financial Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Services provided: Hospice Hospice Facility or Unit Palliative Care

**Please answer the following questions:**

What type of care does your organization provide? Inpatient Outpatient Inpatient and Outpatient

Does your hospice operate a hospice residential facility? Yes NO

Is your hospice a member of the National Hospice and Palliative Care Organization (NHPCO)? Yes NO

Provider Membership Dues Calculation

#### How to Calculate Your Organization’s Dues

Provider dues are based on the total hospice patient days for the last fiscal year under a single Medicare Provider #. The minimum dues for an organization are $450 and the maximum dues per organization including multiple locations are $7,500. Dues for palliative care programs are $450.

* Calculate dues based on the most recently completed fiscal year.
* The total number of patient days includes all patient days counted under a single CMS Iowa Provider Identification Number.
* The total number of patient days for hospices with multiple locations should include patient days from all locations.
* If your hospice had 4,090 or fewer patient days in your last fiscal year, your agency pays the MINIMUM dues of $450.
* MAXIMUM dues payment for an entire agency and all locations is $7,500.
* Providers that ONLY provide Palliative Care services are $450. NOTE: \*This applies to palliative care programs that operate in a hospital or other health care setting and provide for or plan specialized care to patients with advanced or serious illness and their families.

**Please enter the exact number of hospice patient days regardless if your agency’s total hospice patient days are above or below the maximum. Direct questions to: Stephanie Dabney at (515) 243-1046.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Provider Name | City | Medicare Provider ID # | Total Patient Days | Multiply Total Patient Days  x $.11 | Sum of previous  column or a maximum of  $7,500 |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Subtotal** | | | | |  |
| **Are you ONLY a Palliative Care Provider?\***  **(If YES, please write $450; if NO please leave blank)** | | | | |  |
| **Total Enclosed**  **(Minimum total is $450.00 and Maximum total $7,500)** | | | | |  |

**Mail completed form and payment to:**

HPCAI

100 East Grand Avenue, Suite 120 Des Moines, IA 50309

**FOR HPCAI USE ONLY:**

Date Received: Amount of Check: Check #