



2023 PROVIDER MEMBERSHIP FORM

CONTACT INFORMATION

Name of Hospice and/or Palliative Care Program: _____

Address: _____ City: _____ State: _____ Zip _____

Phone: _____ Fax: _____

Website: _____

**The information above will be listed in NHPCA's membership directory.*

Director Information:

Name: _____ Title: _____

Email: _____ Phone: _____

Alternate Representative Information:

Name: _____ Title: _____

Email: _____ Phone: _____

COUNTIES OF SERVICE _____

CITIES OF SERVICE _____

A Provider Member is any licensed hospice organization or palliative care provider that actively provides direct care. To become a Provider Member, **all multiple locations must be listed on the membership form and calculated upon submission of dues.** Hospice providers within a multi-hospice provider organization may only become a member if all the providers of the multi-provider organization become or are members of NHPCA. No additional multiple location fees will be required for hospice providers with an annual census of less than 50 admissions.

PLEASE SUBMIT RENEWAL FORM AND PAYMENT TO NHPCA

1519 M Street, Cozad, NE 69130 • Phone (402) 477-0204 • Email Info@nehospice.org

STAFF MEMBERS

List staff members that should be in NHPCA's database. Staff members will receive NHPCA's e-newsletter, *Hospice News Nebraska* and will gain access to the members-only section of nehospace.org.

- 1. Name: _____ Email: _____
Title: _____
- 2. Name: _____ Email: _____
Title: _____
- 3. Name: _____ Email: _____
Title: _____
- 4. Name: _____ Email: _____
Title: _____
- 5. Name: _____ Email: _____
Title: _____

MEMBERSHIP DUES (Complete the dues calculation below)

OPTION 1 - Hospice programs and hospice programs that *also* provide palliative care

Base Price \$675	\$ _____
Number of hospice admissions in calendar year 2022	_____
x \$7.75 per admission	\$ _____
Number of multiple locations (as licensed by State of Nebraska)	_____
x \$200 per multiple location	\$ _____
Total Dues for 2023	\$ _____

OPTION 2 - Palliative care program (select this option only if your program does not provide hospice)

Base Price \$500	Total Dues for 2023	\$ _____
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PAYMENT INFORMATION

- Check Enclosed (Payable to NHPCA)
- Invoice
- Credit Card →

Cardholder's Name (PRINT) _____

Credit Card # _____

Expiration Date _____ CVC # _____

Cardholder's Billing Address, City, State, Zip _____

Cardholder's Email _____

Signature _____

Your signature on the line above will authorize this transaction. ↑

Signature _____ Date _____

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MULTIPLE LOCATION INFORMATION
(Please fill out for each location)

CONTACT INFORMATION

Name of Hospice: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Website: _____

**The information above will be listed in NHPCA's membership directory.*

Director Information:

Name: _____ Title: _____

Email: _____ Phone: _____

Alternate Representative Information:

Name: _____ Title: _____

Email: _____ Phone: _____

COUNTIES OF SERVICE _____

CITIES OF SERVICE _____

MULTI LOCATION STAFF MEMBERS

List staff members that should be in NHPCA's database. Staff members will receive NHPCA's e-newsletter, *Hospice News Nebraska* and will gain access to the members-only section of nehospice.org.

1. Name _____ Email _____
Title _____

2. Name _____ Email _____
Title _____

3. Name _____ Email _____
Title _____

4. Name _____ Email _____
Title _____

5. Name _____ Email _____
Title _____

6. Name _____ Email _____
Title _____

7. Name _____ Email _____
Title _____

8. Name _____ Email _____
Title _____

9. Name _____ Email _____
Title _____

10. Name _____ Email _____
Title _____