GEORGIA Hospice & Palliative Care ORGANIZATION

Georgia's Expert Resource for Hospice and Palliative Care

NOTE: If you are a hospice with multiple locations and are submitting your membership renewal for all locations at once, please complete a copy of this page for EACH additional location and return with your application.

NEW Provider Membership Application

(Membership year runs April 1 – March 31)

Section I: Contact Information.

Name of Organization: _____

Address: _____ _____ _____ _____ _____

(Street) (PO Box) (City) (State) (Zip Code)

Phone: (_ _ _) _ _ _ - _ _ _ _ Fax: (_ _ _) _ _ _ - _ _ _ _ Website: _____

Primary Contact Name: _____Title: _____ *Email*: _____

(Primary Contact person will receive all mailings, etc. from GHPCO and will be listed as the primary contact on the GHPCO website as well as serve as the Voting Delegate at the Annual Conference)

Additional Email Contacts for Information (education, clinical, regulatory, etc):

Name: _____ *E-mail:* _____

Name: _____ *E-mail:* _____

Name: _____ *E-mail:* _____

Section II: Changes to Organization Information:

Please document any changes to information submitted previously for accurate reflection in the online database and member records.

Counties served: _____

Does your organization operate a Hospice In-Patient and/or Residential Facility? ☐ Yes ☐ No

If yes, please provide the following:

Hospice Facility/Unit Name: _____

Address: _____ _____ _____ _____ _____

(Street) *(PO Box)* *(City)* *(State)* *(Zip Code)*

Phone: (_ _ _) _ _ _ - _ _ _ _ Fax: (_ _ _) _ _ _ - _ _ _ _ Website: _____

Primary Contact: _____ Title: _____ *Email*: _____

What is the total number of beds in the facility/unit named above? _____

Accredited by: ☐ Not accredited ☐ JCAHO ☐ CHAP ☐ ACHC ☐ Other (please specify): _____

Member of NHPCO?: ☐ Yes ☐ No

Member of NAHC?: ☐ Yes ☐ No

Separate non-hospice Palliative Care Program? ☐ Yes ☐ No

Pediatric Hospice/Palliative Care Program? ☐ Yes ☐ No

Section III- Membership Fees

A. Hospice Providers

The Georgia Hospice and Palliative Care Organization charges dues based upon a minimum annual fee of $450.00 (Basic level) plus $3.50 per new patient admitted in the previous calendar year, up to a maximum of $10,000.00.

Calculate dues based on patient admits for previous calendar year plus membership level

A	**Provider Membership Minimum Fee (BASIC LEVEL)**	**$450.00**
B	**Total Number of new Patients admitted in previous calendar year**	
C	Per Patient Fee = $3.50	**$3.50**
D	**Patient Sub-total = (C x D)**	
	TOTAL	
E	***Corporate Flat Rate – organizations with 5 or more locations licensed in the state of Georgia***	***$10,000***
F	***Non-Hospice Palliative Care Provider Member FLAT RATE***	***$250.00***
	TOTAL DUES CALCULATED	

Total number of locations covered by this Application: _____

B. Palliative Care Program Providers

The Georgia Hospice and Palliative Care Organization charges palliative care program dues of $ 250 per year (no prorated dues are offered). Palliative Care providers receive basic membership benefits.

C. Anthony Leatherwood Leadership Legacy Scholarship donation: _____

Scholarship supports attendance for a rising hospice leader at the GHPCO annual conference and the NHPCO Management Development Program in Washington DC in honor of Anthony Leatherwood, former GHPCO board president and tireless hospice leader.

Total Dues Payment Submitted for this membership year: _____

Everything stated in this form is correct and complete to the best of my knowledge.

Person completing this form: _____

(Signature) (Title) (mm) (dd) (yy)

Please *Print* Your Name: _____ Date: _____ / _____ / _____

NOTE: Only Provider members in good standing (i.e. existing, current members who have paid their dues in full) shall be eligible to nominate and vote at the Annual Conference to elect directors to the GHPCO Board. Only representatives from Provider members in good standing shall be elected to serve on the Board of Directors of GHPCO.

Questions: Please, feel free to contact the GHPCO office at toll-free 877-924-6073 or email us: admin@ghpco.org

PAYMENT

Please send the:

1. **Completed Provider Membership RENEWAL form**
2. **A copy of your organization's State of Georgia License (from DCH – not business license)**
3. **This Payment form... and**
4. **Payment**

TO: **Georgia Hospice and Palliative Care Organization**
950 Eagles Landing Parkway
Suite #622
Stockbridge, GA 30281
Or via fax to **678-623-0175**

Payment may be made by check or credit card as indicated. Credit cards are processed via PayPal and may reflect on statements as "PayPal" as well. Please make check(s) payable to "GHPCO".

Check _____ Check No. _____ Date: _____ Amount: _____

MasterCard _____ Visa _____ American Express _____

CARD No.: _____ Expiration Date: ____/_____
(mm) (yy)

CVV (3 digits on back or 4 digits on front if AMEX) _____

Billing Address: _____ zip _____

Cardholder's Name (Please Print):_____

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Georgia Hospice and Palliative Care Organization

INVOICE # 001
DATE: JULY 10, 2024

950 Eagles Landing Parkway Suite 622
Stockbridge, GA 30281
Phone 404-323-9397 Fax 678-623-0175
admin@ghpco.org

TO GHPCO Provider Member
Join or Renew Your Membership Dues Now!

SALESPERSON	JOB	SHIPPING METHOD	SHIPPING TERMS	DELIVERY DATE	PAYMENT TERMS	DUE DATE
Paula Sanders	Membership	N/A			Due on receipt	04/01/2021

QTY	ITEM #	DESCRIPTION	UNIT PRICE	DISCOUNT	LINE TOTAL
	Basic Dues	Base Hospice Provider Rate	$450		**$450**
	Basic Dues	Palliative Care Provider Rate	$250		
	Hospice Provider DUES	**Membership dues renewal for 2022-2023 membership year** **$3.50 per admission**	$3.50/admission		
			TOTAL DISCOUNT		
				SUBTOTAL	
				SALES TAX	-
				TOTAL	

Submit attached Membership Renewal form with dues calculation to admin@ghpco.org or fax to 678-623-0175

Make all checks payable to Georgia Hospice and Palliative Care

THANK YOU FOR YOUR BUSINESS!