

**California Hospice & Palliative Care Association  
California and Nevada Provider/Branch Office Membership Application**

**-- 2007 MEMBERSHIP FORM --**

Agency Name: \_\_\_\_\_  
Corporate Parent (if any): \_\_\_\_\_ (ex. Adventist, Kaiser)  
CHAPCA Contact Person: \_\_\_\_\_  
Job Title/Licenses (RN, etc.): \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ FAX: \_\_\_\_\_  
E-Mail\*: \_\_\_\_\_

*\*On a separate sheet list the name and e-mail address for any staff person wishing to receive e-mail updates/Quicklink*

Website: \_\_\_\_\_  
Is this office a:    Main Facility/Office            Branch/Multiple-location Office  
If Branch, Name of Main Office: \_\_\_\_\_

*Please check all that apply*

Licenses:    Hospice            Home Health            Skilled Nursing Facility  
               Congregate Health Living Facility    Volunteer Hospice Program  
               Residential Care Facility for the Elderly

Certifications:    Medicare           Medicare Provider #: \_\_\_\_\_  
                       Medicaid

Accreditations:    JCAHO – Joint Commission on Accreditation of Healthcare Organizations  
                       CHAP – Community Health Accreditation Program

Counties Served: \_\_\_\_\_  
*All Counties where THIS OFFICE/BRANCH provides service.  
Service areas for additional branch/program offices should only be listed with that office/site.*

Status:    Proprietary (For Profit)                    Not for Profit

Facility Type:    Hospice/Stand Alone                    Hospital-based  
                       Home Health Agency-based            Skilled Nursing Facility-based  
                       Congregate Living Health Facility-based  
                       Residential Care Facility for the Elderly-based  
                       Adult Day Health Care Facility

Inpatient Facilities:    Yes    No   If YES, how many beds? \_\_\_\_\_  
*(should reflect facilities your program actually operates, i.e., hospice house or special facility)*

**PLEASE COMPLETE ATTACHED FORM TO CALCULATE**

**-- 2007 MEMBERSHIP DUES --**

**QUESTIONS? – Contact the CHAPCA Membership Director  
Phone: (916) 925-3770 / e-mail: babramson@calhospice.org**

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1. **PROVIDER MEMBER DUES** are based on the most recent fiscal year's actual operating expenses. Please check the box below that reflects your actual operating expenses for 2006.

- Less than \$99,999 ..... \$435
- \$100,000 - 999,999..... \$1,675
- \$1,000,000 - 4,999,999..... \$2,575
- \$5,000,000 - 9,999,999..... \$3,850
- More than \$10,000,000..... \$5,500

2. **VOLUNTEER HOSPICE DISCOUNT:** Volunteer hospices that do not charge for services and do not receive any payment for services rendered qualify for a 10% discount on base dues.

3. **MULTIPLE LOCATIONS (BRANCH OFFICES):** Additional hospices operating under the same Medicare provider number may join CHAPCA for **\$435** per location.\* Each multiple location will receive CHAPCA mailings, Hospice Notes and QuickLink, discounts on educational conferences, and a listing on the Association's website. Only the parent agency will have a vote. (Please complete a copy of page 1 for each program office joining CHAPCA.)

4. **CORPORATE DISCOUNT:** Corporations with more than 3 member hospices providing services under separate Medicare provider numbers qualify for a 20% discount on annual dues for any additional memberships. The 3 hospices with the highest estimated operating expenses must pay full dues. In order to receive a corporate discount, please complete the information below to calculate dues and provide similar agency information for each office as appears on page 1. Each program will have a vote. (Please complete a copy of page 1 for each program office joining CHAPCA.)

**List the 3 hospices with the highest estimated operating expenses and their full dues based on the table above:**

Program #1 _____	Dues \$ _____
Program #2 _____	Dues \$ _____
Program #3 _____	Dues \$ _____

**List additional hospices operated by the corporation:**

Program #4 _____	Dues \$ _____	x .80 = \$ _____
Program #5 _____	Dues \$ _____	x .80 = \$ _____
Program #6 _____	Dues \$ _____	x .80 = \$ _____

**Total corporate dues: \$ \_\_\_\_\_**

**PLEASE COMPLETE REVERSE SIDE TO CALCULATE**

**-- 2007 MEMBERSHIP DUES --**

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Using information on the reverse side of this form, please calculate your total CHAPCA Membership Dues for 2007:

BASE PROVIDER MEMBER DUES: \$ \_\_\_\_\_  
Less Qualified Volunteer Program Discount: (\$ \_\_\_\_\_)  
Plus Number of additional branches \_\_\_\_\_ @ \$435 ea. \$ \_\_\_\_\_  
OR ..... Total of Corporate Dues \$ \_\_\_\_\_

TOTAL DUES OWED \$ \_\_\_\_\_

Additional contribution to support the California Hospice Foundation: \$ \_\_\_\_\_

TOTAL AMOUNT ENCLOSED \$ \_\_\_\_\_

**Membership Agreement:**

As an applicant to the California Hospice & Palliative Care Association, I/we do affirm to voluntarily abide by and support the goals and objectives of the organization. In addition, I/we agree to accept fax and e-mail communications from CHAPCA & CHF (California Hospice Foundation) relative to the business of the Association and the Foundation.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Method of Payment:**

- Full Payment Enclosed     Payment Plan – 50% Due with Renewal (Balance Due June 1, 2007)  
 Check (Payable to CHAPCA)     AMEX     Discover     MasterCard     Visa

Card No: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Card ID #: \_\_\_\_\_

\_\_\_\_\_  
Customer Signature (required if using credit card)

\_\_\_\_\_  
Name on credit card (please print)

\_\_\_\_\_  
Address where credit card bill is received

\_\_\_\_\_  
City, State, Zip

**Mail to:**

**California Hospice &  
Palliative Care Association  
3841 N. Freeway Blvd., #225  
Sacramento, CA 95834  
FAX: 916/925-3780**

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