

CHAPCA Organizational Membership Form

Agency Name: _____
Corporate Parent (if any): _____ (ex. Adventist, Kaiser)
Agency's CHAPCA Contact: _____
Job Title: _____
Licenses: _____ License #: _____
Address: _____
City, State, Zip: _____
Phone: _____ FAX: _____
Toll Free #: _____
E-Mail: _____
Website: _____



CHAPCA Membership Directory Listing

Please check all that apply. This information will be used as part of your membership listing.

Facility Type:

- Hospice/Freestanding
- 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

Status:

- Proprietary (For Profit)
- Not for Profit

Is this office a:

- Main Facility/Office
- Branch/Multiple-location Office

If Branch, Name of Main Office:

Licenses:

- Hospice
- Home Health
- Skilled Nursing Facility
- Congregate Health Living Facility
- Residential Care Facility for the Elderly
- Volunteer Hospice Program (non-licensed)

Inpatient Facilities: (should reflect facilities your program actually operates, i.e., hospice house or special facility)

- Yes If YES, how many beds? _____
- No

Certifications:

- Medicare -- Medicare Provider #: _____
- Medicaid

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.

Dues to CHAPCA are not deductible as a charitable contribution but may be deductible as an ordinary and necessary business expense. However, a portion of dues is not deductible as a business expense to the extent that CHAPCA engages in lobbying. The nondeductible portion of dues is currently 7%.

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

Printed Name

Date

Please complete this page for each location you are submitting membership applications for.

CHAPCA Membership Dues

Membership Type Provider Palliative Care RCFE

MEMBERSHIP DUES CALCULATION

BASE MEMBER DUES : _____ \$

Plus number of additional branches _____ @ \$435 ea. _____ \$

OR Total Corporate Dues from below _____ \$

TOTAL DUES OWED _____ \$

Less Volunteer (non-licensed) Program Discount (10%): _____ \$

Tax Deductible Contribution to support the California Hospice Foundation: _____ \$

TOTAL AMOUNT ENCLOSED _____ \$

CORPORATE DISCOUNT CALCULATION

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.

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

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 = \$ _____
Program #7 _____	Dues \$ _____ x .80 = \$ _____
Program #8 _____	Dues \$ _____ x .80 = \$ _____

Total corporate dues: \$ _____

DUES SLIDING SCALES

PROVIDERS

Based on the previous year's operating expenditures for hospice programs:

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

PALLIATIVE CARE

Professional (individual)	\$95
Less than 100 consultations.....	\$300
101 to 300 consultations.....	\$500
301 to 500 consultations	\$750
More than 501 consultations.....	\$1000

RCFE PROGRAMS

1 - 6 Beds	\$50
7 - 15 Beds	\$75
16 - 49 Beds	\$100
50+ Beds.....	\$175

Method of Payment:

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

Card No: _____ Exp. Date: _____ Card ID #: _____

Signature (required if using credit card) _____ Name on credit card (please print) _____

Card Billing Address _____ City, ST, Zip _____

**Send BOTH PAGES of Application with Payment To:
CHAPCA, 3841 North Freeway Blvd., Ste. 225, Sacramento, CA 95834; FAX 916-925-3780**