CHAPCA Provider Membership Form (2020)

Organization Name: _____

Corporate Parent, if any: _____ (ex. Adventist, Kaiser)

Org. Contact Name: _____

Job Title: _____

License CPDH: **License #:**_____

Address: _____

City, State, Zipcode: _____

Phone Number: _____ **FAX:** _____

Toll Free Number: _____

E-Mail Address: _____

Website Address: _____

CHAPCA Membership Directory Listing

Please check all that apply. This information will be used as part of your organization's directory listing.

Facility Type:
❒Hospice/Freestanding
❒Hospital-based

Status:
❒ Proprietary (For Profit) ❒ Not for Profit

Licenses:
❒ Hospice
❒ Volunteer Hospice Program (non-licensed)

Provider Number
❒ Medicare -- Medicare Provider #:_____
❒ Medi-Cal--Medi-Cal Provider #:_____

Accreditations:
❒ JCAHO Joint Commission on Accreditation of Healthcare
❒ CHAP Community Health Accreditation Program
❒ ACHC Accreditation Commission for Health Care

Is this location a:
☐ Parent Location ☐ Branch Location

If you are enrolling branch locations, include name and address of each branch on page 3 of this application.

Inpatient Facilities: (should reflect facilities your program actually operates, i.e. hospice house)
❒ Yes If YES, how many beds? _____
❒ No

Languages Spoken: _____

Do you offer a palliative program for patients not eligible or ready for hospice? ❒ yes ❒ no If yes, who is the intended patient?
_____

Counties Served: All Counties where your **PARENT** location provides service. Service areas for additional branch/program offices should only be listed with that office/site on page 3 of this application.
_____

_____

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 relative to the business of the Association.

_____ _____ _____
Signature of Applicant Printed Name Date

CHAPCA Membership Dues

Membership Type ☑ Provider

MEMBERSHIP DUES CALCULATION

BASE MEMBER DUES : $_____

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

OR ..... Total Corporate Dues from below $_____

TOTAL DUES OWED $_____

All Volunteer hospice, Non-Licesed Program Discount:10% $_____

(10%): Tax Deductible Contribution to support CHAPCA: $_____

TOTAL AMOUNT ENCLOSED: $_____

DUES SLIDING SCALES

Hospice Providers: Based on prior year operating expenditures from hospice program oshpd report section 10 line 54: https://siera.oshpd.ca.gov/default.asp

0-$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

Call CHAPCA at 916-925-3770 if your agency has not submitted an oshpd report.

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: $ _____

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 ALL PAGES of Application with Payment To:
CHAPCA: info@calhospice.org or PO Box 340698 Sacramento, CA 95834 or
FAX 916-925-3780

CHAPCA Provider Membership

If you are joining as a branch location, please use this form to provide the information for your branch office.

Branch 1:
Organization Name:
Address:
City, State, Zipcode:
Counties Served:

Branch 2:
Organization Name:
Address:
City, State, Zipcode:
Counties Served:

Branch 3:
Organization Name:
Address:
City, State, Zipcode:
Counties Served: