CHAPCA PROVIDER MEMBERSHIP FORM

Organization Name: _____

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

Organization Contact Name: _____ **Title:** _____

***Designated Voting Member:** _____

License CDPH Number: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: _____ **Fax number:** _____

Toll Free Number: _____

Email Address: _____ **Website Address:** _____

* The designated voting representative of a Provider Member on the records of the Corporation at the time of a vote shall be the only individual entitled to vote on behalf of the Provider Member upon matters put to the voting membership.

CHAPCA Membership Directory Listing

Facility Type:

___ Hospice/Freestanding

___ Hospital-based

Status:

___ Proprietary (For Profit) ___ Non 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.

_____

Send ALL pages of application with payment to CHAPCA: 8153 Elk Grove Blvd. Suite 20 Elk Grove CA 95758 (mail)

info@calhospice.org (E-mail)

CHAPCA Provider Membership Dues

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-Licensed Program Discount: 10% $_____

(10%): Tax Deductive 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://reports.siera.oshpd.ca.gov/

$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, State, Zip

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info@calhospice.org (E-mail)

PROVIDER MEMBERS

ONLY licensed and certified or pending license and/or certification Hospice and Palliative Care organizations are eligible for provider membership in CHAPCA.

Provider member dues are based on current reported OSHPD operating expenditures. All same owner and corporate owner locations are required to become members.

Providers with parent and branch locations process each location separately.

Providers with more than 3 or more parent hospice locations (separate license numbers) qualify for a 20% discount on provider dues. The parent location with the highest OSHPD operating expenditures pay full sliding scale dues. Each additional parent location is eligible for a 20% discount off sliding scale dues.

Please refer to your previous year's OSHPD report to determine your annual dues amount. This can be found at this link (PDF section 10, line 54): https://reports.siera.oshpd.ca.gov/

Each CHAPCA provider member (parent and branch) location will be included in CHAPCA's print and on-line provider referral directory, have access to member only resources and eligible for member pricing on products and services.

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 e-mail communications from CHAPCA relative to the business of the Association.

CHAPCA dues are not deductible as a charitable contribution but may be deductible as an ordinary and necessary business expense. 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%.

Please contact CHAPCA at (916) 925-3770 or mailto:info@calhospice.org if you have questions on processing your provider member application.

Membership Dues are nontransferable to a new license and non-refundable

Signature of Applicant	Printed Name	Date

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info@calhospice.org (E-mail)

CHAPCA PROVIDER MEMBERSHIP FORM

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, Zip code: _____

Counties Served: _____

Branch 2:

Organization Name: _____

Address: _____

City, State, Zip code: _____

Counties Served: _____

Branch 3:

Organization Name: _____

Address: _____

City, State, Zip code: _____

Counties Served: _____

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info@calhospice.org (E-mail)