# 2020 KHPCO PROVIDER MEMBERSHP APPLICATION

## Section A. Contact Information

**Primary Contact*:** **Title**:
**Company:** **Medicare Provider Member #:**
**Address**:
**City:** **State:** **Zip:**
**Phone:** **Fax:**
**Email**:

***Individual who will receive all Provider information from KHPCO, be listed as the as the primary contact on the KHPCO Website and Membership Directory and serve as Voting Delegate.*

**Our Corporate Office Information (if different from above):**

**Company Name:**
**President/CEO:**
**Address:**
**City:** **State:** **Zip:**
**Phone:** **Fax:**

**For consumer information:**

**What number should consumers call for further information? _____**

**Is there a specific person that consumers should ask to speak with? _____**

**Do you have a website you would like us to note in the directory? If so, please give us the URL:**

## Section B. KHPCO Provider Dues

KHPCO Provider dues are based on the number of new hospice patients admitted in the previous calendar year (January 1 to December 31, 2019) for *all hospice multiple locations affiliated with the primary location**, regardless of reimbursement. **Minimum Dues are $250.**

**Dues Formula A:**

A. Total number of new patients admitted in **past 12 months**: _____
B. Assessment per patient: $ 7.00
C. Multiply patients x $7.00 to calculate your dues (A x B = C): _____
D. Minimum Dues are $250 per year. If line C is less than $250, please pay minimum dues. _____

Maximum dues = $9,000

*KHPCO defines Hospice Multiple Locations as additional hospice service sites under one corporation. The Multiple Locations of Provider members receive membership mailings and discounts. All mailings for Multiple Locations will be sent to the designated primary contact at the Multiple Location.

**KHPCO PROVIDER MEMBERSHIP APPLICATION**

**Section C. Special Offer: Providers joining both NHPCO & KHPCO receive a 5% discount on their KHPCO dues!**

**IF Your hospice also joins NHPCO, please reduce your dues by 5%.**

Complete this section if you also join NHPCO:

A. KHPCO Dues per Formula (see Section B above): _____

A. Multiply Dues by 0.05 _____

B. Subtract the 5% Discount from B…dues due to KHPCO _____

C. Total dues due to KHPCO _____

**Section D. Payment Instructions**

**Please mail payment (in full or first installment) with completed forms to KHPCO by March 1, 2020. Make a copy of all forms for your records prior to mailing. Minimum dues are $250. Federal Tax ID:** 48-1082137.

☐ My check is enclosed in full. PLEASE MAKE CHECK PAYABLE TO THE LIFE PROJECT AND NOTE IT IS FOR KHPCO DUES.


☐ I would like to pay in two installments. I understand that a check for half of my dues must be included with this form and must be received by KHPCO before March 1, 2020. I further understand that the remaining payment must be received by May 31, 2020.

Check Number:_____ Amount Included $ _____

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

Signature of Person who completed form: _____

Please print name: Date: _____

*Membership dues are non-refundable. Please note that 98% of your due's payment may be tax deductible as an ordinary and necessary business expense. Approximately 2% of your membership dues payment will go towards lobbying efforts and is not tax deductible. This information is not intended as tax advice. Please contact your tax professional for tax advice.

**Please return all forms with payment by March 1, 2020 to:**

LIFE PROJECT/KHPCO,
313 S. Market
Wichita, KS 67202.

**Have Questions? Please send email to info@khpco.org**

## Program Information

1. Number of Patients Served at this location: _____

2. My hospice is (choose one):
☐ Operating as a Hospice
☐ In the Planning Stages

3. Dominant Ownership Status (choose one):
☐ Independent/Freestanding Hospice Corporation
☐ Division of Health Plan
☐ Division of Hospital
☐ Division of Home Health Agency
☐ Division of Nursing Home
☐ Division of Prison
☐ Division of Veterans Facility
☐ Other (please explain): _____

4. Incorporation Status:
☐ Non-profit
☐ For-profit
☐ Government

## Section B. Location Information (to provide accurate referrals)

Counties Served: (The county/counties will be listed in the online directory.)

### Hospice-dedicated facility/unit Status

Does your program operate a hospice-dedicated facility/unit consisting of one or more beds, which are owned or leased by my hospice, staffed by my hospice staff and has major policies/procedures set by your hospice?

☐ **Yes**, my program operates a hospice-dedicated facility/unit consisting of _____ (#) beds, which are owned or leased by my hospice, staffed by my hospice staff and has major policies/procedures set by my hospice. .

☐ **No**, my program does not operate a hospice-dedicated facility/unit. (The answer is "No" if you have contractual arrangements with other facilities in which the other facility provides basic staff and services while the hospice team visits to establish and oversee the plan of care.)

**Everything stated in this form is correct and complete to the best of my knowledge. Please sign this form and attach all three pages and return all pages with your due's payment.**

Signature/Title of Person Completing This Form

_____

Please Print Your Name Date

_____

**Please include names and email address of those you would like to receive KHPCO mailings:**

Name: Email:

Name: Email:

Name: Email:

Name: Email:

Name: Email:

Name: Email:

Name: Email:

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Name: Email:

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