KHPCO
Kansas Hospice and Palliative Care Organization

2023 KHPCO PROVIDER MEMBERSHP APPLICATION

Section A. Contact Information

Primary Contact*: **Title**:
Company: **Medicare Provider #:**
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 provide us the URL:

_____

2023 Only Special Dues offer!

Section B. KHPCO Provider Dues

For 2023, KHPCO Provider dues will remain at $250 for each member organization!

KHPCO PROVIDER MEMBERSHIP APPLICATION

Section C. Payment Instructions

Please mail $250 payment with completed forms to KHPCO by March 1, 2023. Make a copy of all forms for your records prior to mailing.

Federal Tax ID: 48-1082137.

PLEASE MAKE CHECK PAYABLE TO THE LIFE PROJECT AND NOTE IT IS FOR KHPCO DUES.

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 100% of your due's payment may be tax deductible as an ordinary and necessary business expense.

Please return all forms with payment by March 1, 2022, 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

5. Palliative Care Status:
☐ Not considering currently
☐ In the Planning Stages
☐ Operating

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 payment for dues.

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:

Name: Email:

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