Oklahoma Hospice

& Palliative Care Association

2010 Membership Application

Purpose of the

To advocate for quality hospice care throughout the state of Oklahoma and provide public awareness regarding end-of-life issues, while networking and supporting hospice organizations throughout the state of Oklahoma.

Benefits of Membership

- Increased hospice awareness in the medical community and the general public at-large through press releases available to the membership.
- Organized network of hospices facing end-of-life issues and hospice care in Oklahoma.
- Legislative presence at both a state and national level.
- Networking with other hospice care providers through educational events, committee meeting, discipline meetings, monthly board of directors meetings, web site interaction and shared provider information.
- Reduced rates for all OHPCA sponsored events.
- Continuing education opportunities for team members.
- Information & visibility through the OHPCA's web site at www.okhospice.org. The website serves as a source of information to hospice professional as well as patients and families. The website contains a hospice search engine where anyone can search for a OHPCA member hospice.
- E-Newsletter from OHPCA providing relevant and current information regarding hospice care issues in the state of Oklahoma.
- Weekly Hospice News Network e-newsletters available in the "members only" section of the website.
- Wide variety of committee involvement. There are nine official committees and seven committees open to the membership for involvement and leadership.
- Discipline specific group meetings that are designed for learning, sharing and networking.

16307 Sonoma Park Dr, Suite 2
Edmond, OK 73013

2010 Membership Application

Please complete this form & mail it with appropriate dues to:

Oklahoma Hospice & Palliative Care Association
16307 Sonoma Park Dr., Ste 2
Edmond, OK 73013

Please Note: This form must be completed in its entirety. All information in this application will be verified with the Oklahoma State Licensure. Incomplete applications and/or discrepancies found may delay membership activation.

Section A. Contact Information

Name of Hospice (Primary Location): ______________________________

Primary Contact* ______________________ Title: ______________

Mailing Address: ______________________________

Street Address: ______________________________

City: ______________________ State: ________ Zip: __________

Telephone: ______________________ Fax: ______________________

E-mail Address for primary contact: ______________________________

Web Site: ______________________________

Counties Served (useful for OHPCA member directory & referrals) ______________________

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*Individual who will receive all mailings from the OHPCA, be listed as the primary contact on the OHPCA website and online membership directory, serve as Voting Delegate (voting rights only apply to Institutional Memberships).

Corporate Office Information (if different from above):

Company Name: ______________________________

Address: ______________________________

City: ______________________ State: ______________ Zip: __________

Phone: ______________________ Fax: ______________________

Website: ______________________________

List all Alternate Administrative Offices: Alternate Administrative Offices (AAO) are the hospice locations which share the same hospice license number as the primary hospice location listed in Section A of this application. Each of the alternate administrative offices listed will receive the same mailings and discounts that the primary location receives. **Should you have more administrative office locations than space provided below, please copy this page and attach it to this application.**

Additional Hospice locations in your organization that have a separate hospice license/provider number, are required to complete a separate membership application. Each additional licensed hospice must meet the same membership dues requirements as listed under section B of this application**.**

AAO #1

Name: ______________________________

Primary Contact Person: ______________________________

Mailing Address: ______________________________

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Telephone: ____________________ Fax: ____________________

Primary Contact Person's E-mail Address: ______________________________

Web Site: ______________________________

Counties Served (Extremely useful for OHPCA member directory & referrals) ______________________________

____

AAO#2

Name: ______________________________

Primary Contact Person: ______________________________

Mailing Address: ______________________________

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Telephone: ____________________ Fax: ____________________

Primary Contact Person's E-mail Address: ______________________________

Web Site: ______________________________

Counties Served (Extremely useful for OHPCA member directory & referrals) ______________________________

____

Please note: Only employees of the primary location and the employees of the listed AAO will receive member benefits. Other hospice locations affiliated with your organization that have a separate hospice license/provider number are not eligible for member benefits through this membership application. These locations must apply for membership to qualify for OHPCA member benefits.

Section B 2010 Dues

Please mark Membership Choice

OHPCA Institutional dues are based on the number of prior calendar year admissions (January 1 to December 31, 2009) for all hospice locations affiliated with the primary location*. **Minimum Institutional Members Dues are $400.00.**

_____Institutional Hospice Membership Dues Formula:

- **A.** Total number of admissions for 2009 for primary location ____________
- **B.** Total number of admissions for 2009 for all AAO locations listed ____________
- **C.** Add the total of A & B to calculate total admissions ____________
- **D.** Assessment per admission $5.00
- **E.** Multiply C x D to calculate (total admission x $5.00) ____________
- **F.** Minimum Institutional Dues are $400 per year
- **G.** If line E is less than $400, please pay the minimum Institutional dues of $400

Total Dues owed $___________

_____Professional Association Membership (businesses associated with hospice care): **$ 200.00**

_____ Individual Association Membership: **$100.00**

Professional Association and Individual applicants please proceed to Section D. All Institutional Hospice applicants proceed to Section C.

Section C Provider Information

Is your agency a current member of NHPCO? (circle) Yes – No

Please Check All That Apply: (This information is vital for the purposes of statistics)

____	Operational (year started _____)	____	Long-Term-Care Based	____	For-Profit
____	Developing (opening date ____)	____	Hospital Based	____	Non-Profit
____	Private/Corporate Ownership	____	Free Standing / Independent		
____	Community Ownership	____	Home-Health Based		
____	Medicare Certified	____	In-Patient Facility Plans (projected opening _____)		

Average Daily Census in 2009: ___________ **Average Length of Stay in 2009**: _____________

Do you have a Pediatric Palliative Care Program? _____yes ______no
A pediatric palliative care program is a formal pediatric hospice and /or palliative care program that has dedicated staff with expertise in pediatric palliative care for the provision of pediatric services.

a) If no, do you plan to start a pediatric program in the next 1-2 years? _____yes _____ no

What percentage of your 2009 admissions were non-funded charitable cases? __________

Do you have a service delivery program outside of the model of the Medicare hospice Benefit?
______ Yes ______ No (skip table below) ______ Planning Stages

Program Type	Program Status
Palliative consult services in any setting	____ Active Program ____ Planning Stages
Palliative care services at home or in an inpatient facility (bridge program, pre-hospice programs, etc)	____ Active Program ____ Planning Stages
Post-hospice support for patients discharged alive	____ Active Program ____ Planning Stages
Community bereavement support program (for individuals not associated with friend/family who received hospice services)	____ Active Program ____ Planning Stages
Complementary therapies (music therapy, art therapy, massage therapy, etc.	____ Active Program ____ Planning Stages

Administration – Department Directors: OHPCA uses the contact information below to add to our email list quarterly newsletter, meeting notifications and any other Association communications to members. In order for employees at your Alternate Administrative Offices (AAO) please complete this information for those locations as well. **Please copy this page and attach it to this application. Be sure to note which AAO the information is for. All emails and mailings for AAO will be sent to the AAO designated primary contact if no other contact information is submitted. It will be that primary contact's responsibility to share the information with all other AAO employees.**

Executive Director/Administrator/CEO: ______________________ Email: ______________

Medical Director: ______________________ Email: ______________

Patient Care Coordinator: ______________________ Email: ______________

Social Worker: ______________________ Email: ______________

Volunteer Coordinator: ______________________ Email: ______________

Referrals/Intake: ______________________ Email: ______________

Nurse: ______________________ Email: ______________

Nurse:______________________ Email: ______________

Office / Business Manager: ______________________ Email: ______________

Chaplain: ______________________ Email: ______________

Bereavement Coordinator: ______________________ Email: ______________

Development / Marketing: ______________________ Email: ______________

Oklahoma Hospice & Palliative Care Association Active Committees:

Committee Membership is reserved for **ACTIVE** Members of the OHPCA. Please remember: this is a volunteer association and your voice is important. Please contact Lavane Vowell, COO, if you or any of your staff have any questions or would like to serve on one or more of these committees. **If needed, please attach additional names on separate page.**

Listed below are the active OHPCA committees and their descriptions. If you or someone from your organization is interested in becoming a committed, active member of one or more of these committees, please list their contact information and the committee they are interested in serving on the following page. The committee chairperson as determined by the OHPCA Board of Directors or a Board Member for the committee meetings will contact the potential members.

- **Annual Conference:** *Help plan the annual OHPCA State Conference, select speakers, menus, contact vendors, exhibitors and assist at the Conference.*
- **Membership:** *Promote membership to new & existing hospice programs in Oklahoma & promote retention of current members.*
- **Education:** *Develop & Coordinate educational programs for the OHPCA membership.*
- **Ethics:** *Review hospice practices and provide insight to questions and situations that arise in hospice care. The Ethics Committee will review submitted names and the OHPCA Board of Directors will approve the Ethics Committee membership.*
- **Public Awareness:** *Coordinate media coverage of special events, such as OHPCA State Conference, Hospice Day on The Hill, National Hospice Month, with the C.O.O. and Board of Directors approval. Also, make recommendations to the C.O.O. and Board of Directors for public service announcements, press releases and some content of the OHPCA's web site.*
- **Legislative:** *Promote hospice issues through legislative format and plan the "Hospice Day On The Hill" activity.*
- **HVP (Hospice-Veteran Partnership) Committee:** *Committee members meet quarterly with VA representative to build and develop relationships between community hospice programs and the VA system.*

OHPCA Committee Participation Sign Up

Name: ______________________________ Committee ______________________________

Address: __________________________ City: ________________ State: _____ Zip: __________

Phone: ____________________ Fax: ____________________ Email: ____________________

Name: ______________________________ Committee: ______________________________

Address: __________________________ City: ________________ State: _____ Zip: __________

Phone: ____________________ Fax: ____________________ Email: ____________________

OHPCA Committee Participation Sign Up-cont.

Name: ______________________________________ Committee: _________________________________

Address: ______________________________ City: ____________________ State: ______ Zip: __________

Phone: ______________________ Fax: ______________________ Email: _________________________

Name: ______________________________________ Committee: _________________________________

Address: ______________________________ City: ____________________ State: _____ Zip: __________

Phone: ______________________ Fax: ______________________ Email: _________________________

Name: ______________________________________ Committee:
____

Address: ______________________________ City: ___________________ State: ______ Zip: ___________

Phone: _______________________ Fax: ______________________ Email: ________________________

Name: _____________________________________ Committee: __________________________________

Address: ______________________________ City: ___________________ State: ______ Zip: ___________

Phone: _______________________ Fax: _______________________ Email: _______________________

Name: ____________________________________ Committee:
____

Address: ______________________________ City: ___________________ State: ______ Zip: ___________

Phone: _______________________ Fax: ______________________ Email: ________________________

Section D Payment Instructions

Please mail or fax payment in full with complete form to OHPCA. Make a copy of all forms for your records prior to mailing.

___ My check is enclosed check #______________ amount included $_______________

I am paying by credit card. ____ Visa _____ Mastercard _____ American Express

Account Number: ____ 3 Digit V#(on back of card)_________

Expiration Date: _______________ Name on Card: ____

Signature: ____

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

Signature of Person who completed this form: ____

Please print name____ Date __________________________

Please mail complete form and payment to:

Oklahoma Hospice & Palliative Care Association
16307 Sonoma Park Dr., Ste 2
Edmond, OK 73013

Thank you for your participation and support of the Oklahoma Hospice & Palliative Care Association

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