Welcome to the only association in Virginia that focuses exclusively on Hospice and Palliative Care and the concerns of providers. We are the one association committed to improving end-of-life care and expanding access to all in need across the Commonwealth of Virginia. **Enjoy Member benefits while strengthening the VOICE for hospices and palliative care in Virginia.**

Hospice Provider Members are defined as: Licensed Hospices supporting the VAHPC mission and purpose.

- A multi-site hospice must submit a separate application form for each location to ensure accurate contact information is provided to optimize the "Find a Hospice" function on the VAHPC website.
- A multi-site hospice has the option to calculate dues for each site OR for all sites together accounting for ALL patients served for all sites (See page 2 to calculate dues).
- Sign and date this application and return via mail to VAHPC, P.O. Box 70025, Richmond, VA 23255-0025 or submit via email as a scanned email attachment to mwlindsey@virginiahospices.org.
- Please remit your completed application with payment by check by **March 1, 2020**.
- Make checks payable to VAHPC.

Member/Organization Name: _____

CEO/Hospice Administrator: _____

Local On- Site Key Contact: _____

Address: _____

City: _____Zip Code:_____

Phone: _____

Email: _____

Web Site: _____

PROVIDER INFORMATION

Please list name & email address for the following team members.

	Name	Email
CEO/Executive Director		
Medical Director		
Clinical Manager		
Volunteer Coordinator		
We Honor Veterans Contact		
Other (if desired)		

List ALL cities and counties that you serve:
(If there have been no changes, you may enter N/A).

Counties	Cities

3. Check one: _____ Not-for-profit _____ For- profit

4. Accredited by: Not accredited JCAHO CHAP ACHC Other (please specify):

_____

DUES CALCULATION

Minimum Dues = $400 Maximum Dues = $10,000

Hospice Provider Member dues are based on the number of billable patient days in the most recent calendar OR fiscal year multiplied by 13.4 cents.

Total billable patient days = _____ x 13.4 cents = $_____ (*must be between $400 and $10,000)*

Signature of person completing this form: _____

Phone:_____ Date:_____

Payment Information

Credit Card #: _____ Expiration Date:_____

Name on Card: _____ CVV Code: _____

Card Billing Address: _____

Check Number (if available and paying by check): _____