CHAPCA Organizational Membership Form

Agency Name: ______________________

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

Agency's CHAPCA Contact: ______________________

Job Title: ______________________

Licenses: ______________ **License #:** ______________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________ **FAX:** ______________

Toll Free #: ______________________

E-Mail: ______________________

Website: ______________________

CHAPCA Membership Directory Listing

Please check all that apply. This information will be used as part of your membership listing.

Facility Type:
- ❒ Hospice/Freestanding
- ❒ Hospital-based
- ❒ Home Health Agency-based
- ❒ Skilled Nursing Facility-based
- ❒ Congregate Living Health Facility-based
- ❒ Residential Care Facility for the Elderly-based
- ❒ Adult Day Health Care Facility

Licenses:
- ❒ Hospice
- ❒ Home Health
- ❒ Skilled Nursing Facility
- ❒ Congregate Health Living Facility
- ❒ Residential Care Facility for the Elderly
- ❒ Volunteer Hospice Program (non-licensed)

Certifications:
- ❒ Medicare -- Medicare Provider #:______________
- ❒ Medicaid

Accreditations:
- ❒ JCAHO – Joint Commission on Accreditation of Healthcare Organizations
- ❒ CHAP – Community Health Accreditation Program

Status:
❒ Proprietary (For Profit) ❒ Not for Profit

Is this office a:
❒ Main Facility/Office ❒ Branch/Multiple-location Office
If Branch, Name of Main Office:

____

Inpatient Facilities: (should reflect facilities your program actually operates, i.e., hospice house or special facility)
- ❒ 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 **THIS OFFICE/BRANCH** provides service. Service areas for additional branch/program offices should only be listed with that office/site.

____

____

Dues to CHAPCA are not deductible as a charitable contribution but may be deductible as an ordinary and necessary business expense. However, 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%.

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

______________________ ______________________ ______________
Signature of Applicant Printed Name Date

Please complete this page for each location you are submitting membership applications for.

CHAPCA Membership Dues

Membership Type ❒ Provider ❒ Palliative Care ❒ RCFE

MEMBERSHIP DUES CALCULATION

BASE MEMBER DUES : $__________

Plus number of additional branches ______ @ $435 ea. $__________

OR .... Total Corporate Dues from below $__________

TOTAL DUES OWED $__________

Less Volunteer (non-licensed) Program Discount (10%): $__________

Tax Deductible Contribution to support the California Hospice Foundation: $__________

TOTAL AMOUNT ENCLOSED $__________

DUES SLIDING SCALES

PROVIDERS

Based on the previous year's operating expenditures for hospice programs:

Less than $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

PALLIATIVE CARE

Professional (individual)	$95
Less than 100 consultations	$300
101 to 300 consultations	$500
301 to 500 consultations	$750
More than 501 consultations	$1000

RCFE PROGRAMS

1 – 6 Beds	$50
7 – 15 Beds	$75
16 – 49 Beds	$100
50+ Beds	$175

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, ST, Zip

Send BOTH PAGES of Application with Payment To:

CHAPCA, 3841 North Freeway Blvd., Ste. 100, Sacramento, CA 95834; FAX 916-925-3780