The Carolinas Center
Innovation and Excellence in Advanced Illness at End of Life

TO COMPLETE THIS APPLICATION ONLINE, CLICK HERE

Is this application for new membership or renewal? _____ new _____ renewal

HOSPICE INFORMATION

Hospice Name: _____

Other Names Used by your Hospice: _____

What is your primary hospice license number? _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Organization Main Phone #: _____ Website: _____
Does your hospice currently operate an inpatient unit? _____ Yes_____ No
Does your hospice currently provide palliative care services? (check all that apply)
_____ Community-based services
_____ Inpatient via contractual arrangement outside organization
_____ Inpatient affiliated with own organization
_____ Inpatient affiliated with own organization
_____ Outpatient clinic
_____ None
Does your organization have a home health license?
_____ Yes, in North Carolina
_____ Yes, in South Carolina
_____ Yes, in both NC and SC
_____ No
What are your billing mechanisms? (check all that apply)
_____ Medicare Part A & B
_____ Medicaid
_____ Private Payer
_____ Foundation
_____ Other (please specify) _____
Does your organization provide pediatric care? _____ Yes _____ No
Does your organization provide hospice and/or palliative care in nursing homes? _____ Yes _____ No
Is your organization affiliated with any health system or hospital? _____ Yes _____ No
If so, which one? _____
Is your hospice organization currently accredited?
_____ Accreditation Commission for Health Care (ACHC)
_____ Community Health Accreditation Partner (CHAP)
_____ Joint Commission
_____ Not accredited
Is your organization a partner with NHPCO “We Honor Veterans” program? _____ Yes _____ No
Is your organization a member of any other healthcare associations? _____ Yes _____ No
If so, which ones? _____

_____

_____

What is the tax status of your hospice organization? _____ For Profit _____ Nonprofit

Please list all counties your serve from any of your licensed offices. _____

_____

_____

State issuing primary license: _____

Does your organization maintain multiple locations from which hospice services are provided?
_____ Yes _____ No

If yes, please list provide the following information for all locations:

Location	**Address**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HOSPICE CEO/EXECUTIVE DIRECTOR INFORMATION

Full Name & Formal Title: _____

Phone #: _____ Email: _____
Credentials (circle one):

MSW CPA MBA MSN RN MD PD BSW

BILLING INFORMATION

Organization's Billing Contact Full Name & Formal Title:

_____

Phone #: _____ Email: _____

Would you prefer to be billed annually or quarterly? _____

Total patient days of care for all NC and SC hospice locations from 10.01.2017 – 09.30.2018? _____

ADDITIONAL INFORMATION

Name of person who completed this application:

_____

Email of person who completed this application:

_____