

American College of Health Care Administrators
New Member Application
12-Month Membership Period
 Updated 11-20-09



Contact Information

___ Dr. ___ Mr. ___ Ms. ___ Mrs. ___ Sr. ___ Rev. ___ Other

Name: _____ Credentials: _____
 Home Address: _____
 City/State/Zip: _____
 Home Phone: (____) _____ Cell Phone: (____) _____
 Personal Email: _____
 Title: _____
 Facility/Company: _____
 National Provider Identification Number (NPI): _____
 Business Address: _____
 City/State/Zip: _____
 Business Phone: (____) _____ Fax: (____) _____
 Business Email: _____
 Corporation Name: _____
 Number of Sites: _____ Total Beds: _____
 Preferred Mailing Address: ___ Home ___ Office
 Preferred E-mail Address: ___ Home ___ Office

Demographic Data

Collection of this data will be used for statistical and survey purposes to improve and/or create programs and services to better serve you.

Date of Birth: _____

Gender: ___ Male ___ Female

Race: ___ Black or African American ___ White
 ___ Hispanic or Latino ___ American Indian/Alaska Native
 ___ Pacific Islander ___ Arabic ___ Asian
 ___ Other _____

Check all that apply to your role:

- | | |
|--|---|
| <input type="checkbox"/> Academic | <input type="checkbox"/> Director of Nursing |
| <input type="checkbox"/> Administrator (current) | <input type="checkbox"/> Executive Director |
| <input type="checkbox"/> Administrator (retired) | <input type="checkbox"/> Student |
| <input type="checkbox"/> Administrator-in-Training | <input type="checkbox"/> Product/Service Provider |
| <input type="checkbox"/> Assistant Administrator | <input type="checkbox"/> Vice President/Director |
| <input type="checkbox"/> CEO/COO/President | <input type="checkbox"/> Owner |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dept. Head/Manager | |

Education:

(Check highest level attained)

- Doctoral degree
- Physician
- Masters degree
- Some graduate work
- Bachelor's degree
- Associate degree
- Diploma in nursing
- High school diploma

Clinical Background:

- LPN/LVN
- Registered Nurse
- Rehabilitation Therapist
- Social Worker
- Other _____

Experience

Year you began working as an administrator: _____
 Year you began working in Skilled Nursing: _____
 Year you began working in Assisted Living: _____

Current License

Date originally licensed: _____
 List license information:
 State: ___ Number: _____ Type: _____
 State: ___ Number: _____ Type: _____
 State: ___ Number: _____ Type: _____

Profit Status of your facility:

- Private/For Profit
- Public/For Profit
- Not For Profit
- Government
- Other

Programs (check all that apply):

- Adult Day Care
- AIDS
- Alzheimer's/Dementia
- Assisted Living
- Consulting
- CCRC
- Geriatric center/ Senior center
- Home health
- Hospice
- ICF/MR/DD
- Independent Living/Senior Housing
- Long-Term Acute Care Hospital (LTACH)
- Skilled Nursing Facility (SNF) (check all that apply)
 - Complex medical/subacute
 - Neurological/Head Trauma
 - Pediatric
 - Rehabilitation
 - Ventilator or Pulmonary
 - Wound care
 - Other _____
- University/Academia

Facility Size:

- Up to 10 beds
- 11-25 beds
- 26-50 beds
- 51-100 beds
- 101-200 beds
- 200 or greater beds

Is your organization:

- Management group
- Hospital-based
- Independent Ownership
- Community Ownership
- Corporately Owned
 - National Corporation
 - Regional Corporation
 - Local Corporation
- Integrated delivery system
- Other _____

of clients your organization cares for daily: _____

Communications Options (required)

- On occasion, ACHCA may make its mailing list available to organizations whose products or messages we feel may be of interest to our members. Do you wish to be included in such mailings?
 Opt-in _____ Opt-out _____
- Third party fax communications: Opt-in _____
- Automatic access to members-only Peer2Peer: Opt-in _____

ACHCA will not make your phone number available to vendors or suppliers of services.

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National Dues & Optional Donations:

Membership Category	Description	National Dues (includes chapter dues of \$25)
Full	Administrators or those with substantial interest in health/residential care administration	\$291
Associate	Allied health professionals and individual providers of healthcare products/services	\$192
Bridge	One-year transitional membership for those who have completed education/AIT program	\$141
Business Affiliate	<i>Please contact candrews@achca.org</i>	
Senior Retired	Full members of 15+ years who have retired from healthcare administration and are 65+ years of age	\$164
Student/Administrator-in-Training*	Enrolled in health-related academic or pre-licensure training program and NOT employed as an LTC administrator	\$69

A. Dues

- \$ _____ Dues from above (Primary Chapter Dues are included)
 \$ _____ 2nd Chapter Dues @ \$25.00 per additional chapter; Name of chapter: _____
 \$ _____ (Optional) one-year membership in the Academy of Long Term Care Leadership and Development @ \$50**
 \$ _____ (Optional) life membership in the Academy @ \$500**
 \$ \$25.00 Application fee (\$25.00 Application fee applies to initial applications and lapsed renewals of 12 months or greater; Application fee is waived for Student/AIT Members)
 \$ _____ **Total Dues**

B. Optional, Tax Deductible Donations

- \$ _____ Unrestricted donation/Fund Drive donation
 \$ _____ The Academy of Long Term Care Leadership and Development**
 \$ _____ Richard L. Thorpe Fellowship**
 \$ _____ Sister Joan Cassidy & Michael Cuseo Cultural Diversity Endowment Fund**
 \$ _____ W. Phillip McConnell Student Scholarship Fund**
 \$ _____ **Total Optional Donations**

C. Total Payment:

- \$ _____ A. Dues
 \$ _____ B. Optional Donations
 \$ _____ **C. Total Remitted**

*Applicant must submit proof of academic enrollment or trainee status

** For more information on The Academy of Long Term Care Leadership and Development and ACHCA scholarships, visit www.achca.org

_____ I have enclosed a check payable to ACHCA. Check # _____

_____ Please charge my: ___American Express ___MasterCard ___Visa

Account Number: _____ Expiration Date: _____

Name of Cardholder: _____

Signature of Cardholder: _____

FAX 2-page application with credit card payment to 866-874-1585

Mail application & check payment to ACHCA Membership, PO Box 75060, Baltimore, MD 21275-5060

Questions? Contact: membership@achca.org or 202-536-5120