



Contact Information (*Required items)

___ Dr. ___ Mr. ___ Ms. ___ Mrs. ___ Sr. ___ Rev. ___ Other
Name: _____ Credentials: _____
*Primary Email: _____
Secondary Email: _____
Title: _____
*Facility/Company/School: _____
National Provider Identification Number (NPI): _____
*Home Address: _____
*City/State/Zip: _____
Home Phone: (____) _____ Mobile: (____) _____
*Parent Corporation Name: _____
Number of Sites: _____ Total Beds: _____
Business/School Address: _____
City/State/Zip: _____
Business/School Phone: (____) _____ Fax: (____) _____
Preferred Mailing Address: ___ Home ___ Office/School

***How did you hear about ACHCA? ___ Current Member (list below)**

___ Friend/Colleague ___ ACHCA website ___ NAB
___ Facebook/LinkedIn/Twitter ___ Email promotion
___ LTC publication ___ Other _____

Referred by: Name _____ Chapter _____

Demographic Data (*Required items)

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

*Age: Birth Year _____

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 _____

Students (if applicable):

Year in school: 1 2 3 4
Expected Graduation Date: _____

Experience

NH Administration: ___ 0 years or NA ___ < 5 years ___ 6-10 years
___ 11-15 years ___ 16-20 years ___ 21-25 years ___ >25 years

AL Administration: ___ 0 years or NA ___ < 5 years ___ 6-10 years
___ 11-15 years ___ 16-20 years ___ 21-25 years ___ >25 years

Current License

Date originally licensed: _____
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
- Other _____

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)

1. 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 _____

PRIVACY DISCLOSURE: At ACHCA, we take every precaution to protect your information. We will always respect your email and phone number privacy and will never sell, rent or exchange it to any outside company.



Voting Memberships	Description	National Dues
Professional	Those persons who are professionally qualified by licensure, certification, education, and/or experience, to serve as executives or academics in long term care administration, and who <i>are accountable</i> for ensuring that quality of care is provided in long term care, residential care, and/or post-acute care setting(s).	\$310
Emerging Professional	Same as above licensed or professional qualified less than 2 years.	\$205
Retired Member	Current voting members of continuous 5+ years, who have retired from healthcare administration and are at least 55 years of age. Must submit statement of attestation for proof of retirement with no remuneration for administrative services.	\$100
Retired Fellow	Current voting members who have been a Fellow in good standing of 5+ years, are 55+ years of age, and have retired from healthcare administration. Must submit statement of attestation of proof of retirement with no remunerations for administrative services.	\$80
Non-voting Memberships	Description	National Dues
Associate	Those individuals who have an interest in long-term health care quality and administration, but do not meet the qualifications established for Voting Members.	\$205
Collegiate/AIT*	I Individuals seeking entry to LTC practice as a nursing home, assisted living, or aging services administrator who are enrolled in health-related degree granting, certificate, or diploma program at an accredited college or university, or actively enrolled in an AIT/internship in long term care administration, not already licensed in another profession, and do not meet the qualifications established for Voting Members.	\$47
Business Affiliate	Company membership providing representatives the opportunity to network with long term care leaders at national and state chapter activities.	\$520
Fees	Description	Amount
Application Fee	Applies to all <u>new</u> member applications. Required for all renewals received after 30 days of membership expiration date. Waived for Collegiate/AIT members.	\$25
Lapsed Fellow Renewal Fee	For ACHCA Fellows whose membership has expired >60 days, Fellow status can be reinstated by submitting the abbreviated Fellow application located at www.achca.org/development and paying the Lapsed Fellow Renewal and Membership application fees. The Fellow credential lapses if not current 60 days post membership expiration.	\$250

*Requires proof of academic enrollment (i.e. current student ID and class schedule or tuition bill) or a letter from an AIT preceptor on company letterhead.

A. Dues

\$_____ Dues from above (*Primary Chapter Dues are included*)

\$_____ *Additional Chapter Dues @ \$30.00 per additional chapter; Name of additional chapter(s):* _____

\$ 25.00 Application fee (see description above)

\$_____ Lapsed Fellow Renewal Fee (see description above)

\$_____ **Total Dues (A)**

B. Donation to The Academy of Long Term Care Leadership and Development (tax deductible)

Enter amount:

\$_____ Up to \$99 Academy Friend

\$_____ \$100-\$249 Academy Supporter

\$_____ \$250-\$499 Academy Patron

\$_____ \$500-\$999 Academy Benefactor

\$_____ \$1,000-\$2,499 Academy Champion

\$_____ \$2,500-\$4,999 Academy Pillar

\$_____ \$5,000+ Academy Chair's Circle

\$_____ Fellow Promise: \$1,000/year for 4 years; \$500/year for 4 years; \$250/year for 4 years;

\$_____ (other amount) /year for 4 years

\$_____ **Total Academy Donations (B)**



C. Donations (tax deductible) For more information on donation options, including Legacy Giving, visit www.achca.org.

Enter Amount:

- \$ _____ ACHCA Unrestricted donation/Fund Drive donation
- \$ _____ Student Development (restricted fund for Student/AIT activities)
- \$ _____ Richard L. Thorpe Fellowship
- \$ _____ Sr. Joan Cassidy & Michael Cuseo Diversity Endowment Fund
- \$ _____ W. Phillip McConnell Student Scholarship Fund
- \$ _____ **Total Donations (C)**

D. Total Payment

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

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

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

Please charge my: ___ American Express ___ MasterCard ___ Visa ___ Discover

Account Number: _____ Expiration Date: _____

Name of Cardholder: _____

Signature of Cardholder: _____

FAX – credit card payments to our secure fax at: 866-874-1585

Payment Processing Disclosure: Memberships are non-refundable. Please note that should this charge be disputed by you or any agent acting in your behalf, a service fee not to exceed 5% of the original charge amount may be incurred. Charges are processed through our merchant services provider, PayPal. The item may appear on your statement as PAYPAL ACHCA or PURCHASE AMERICANCOL.

By submission of this membership application, I attest that I have not had a professional license suspended, charged with an ethics violation, or convicted of a crime. In addition, I have read and will adhere to the ACHCA Code of Ethics (<https://achca.org/index.php/about-achca>).

Dues are payable upon receipt in U.S. Funds, drawn on a U.S. bank. For U.S. citizens only: ACHCA membership dues are not deductible as a charitable contribution for U.S. federal income tax purposes, but may be deductible as a business expense under section 162 of the Internal Revenue Code as an “ordinary and necessary business expense.” Please consult your tax professional for more information. Contributions of gifts to ACHCA are deductible as charitable contributions for federal income tax purposes. FEIN: 36-2637617

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