

**Member Profile (\*Required information)**

\_\_\_ Dr. \_\_\_ Mr. \_\_\_ Ms. \_\_\_ Mrs. \_\_\_ Sr. \_\_\_ Rev. \_\_\_ Other

\*Name: \_\_\_\_\_

\*Primary E-mail:

Secondary E-mail:

Job Title:

Credentials:

\*Facility/Company:

National Provider Identification Number (NPI):

\*Home Address:

\*City/State/Zip:

Home Phone:

Mobile:

\*Parent Corporation Name:

Number of Sites:      Total Beds:

Business Address:

City/State/Zip:

Business Phone:

\*Preferred Mailing Address: \_\_\_ Home \_\_\_ Office

\*How did you hear about ACHCA?

\_\_\_ Current Member: \_\_\_\_\_  
 \_\_\_ Friend/Colleague      \_\_\_ ACHCA website      \_\_\_ NAB  
 \_\_\_ Facebook/LinkedIn/Twitter      \_\_\_ E-mail promotion  
 \_\_\_ LTC publication      \_\_\_ Other \_\_\_\_\_

\*Designate your Primary Chapter: \_\_\_\_\_  
 (visit [achca.org/chapters](http://achca.org/chapters) for listing of active chapters)

**Administrative Role(s):**

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"/> Product/Service Provider |
| <input type="checkbox"/> Administrator-in-Training | <input type="checkbox"/> Vice President/Director  |
| <input type="checkbox"/> Assistant Administrator   | <input type="checkbox"/> Owner                    |
| <input type="checkbox"/> CEO/COO/President         | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Consultant                |   |
| <input type="checkbox"/> Dept. Head/Manager        |   |

**Administrator 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: \_\_\_\_\_ (required)

State: \_\_\_\_\_ Number: \_\_\_\_\_ Type: \_\_\_\_\_

State: \_\_\_\_\_ Number: \_\_\_\_\_ Type: \_\_\_\_\_

State: \_\_\_\_\_ Number: \_\_\_\_\_ Type: \_\_\_\_\_

**Profit Status of your facility: Programs (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Private/For Profit | <input type="checkbox"/> Adult Day Care   |
| <input type="checkbox"/> Public/For Profit  | <input type="checkbox"/> AIDS   |
| <input type="checkbox"/> Not For Profit     | <input type="checkbox"/> Alzheimer's/Dementia                                     |
| <input type="checkbox"/> Government         | <input type="checkbox"/> Assisted Living  |
| <input type="checkbox"/> Other _____        | <input type="checkbox"/> Consulting   |
|   | <input type="checkbox"/> CCRC   |
|   | <input type="checkbox"/> Geriatric center/ Senior center                          |
|   | <input type="checkbox"/> Home health  |
|   | <input type="checkbox"/> Hospice  |
|   | <input type="checkbox"/> ICF/MR/DD  |
|   | <input type="checkbox"/> Independent Living/Senior Housing                        |
|   | <input type="checkbox"/> Long-Term Acute Care Hospital (LTACH)                    |
|   | <input type="checkbox"/> Skilled Nursing Facility (SNF)<br>(check all that apply) |
|   | <input type="checkbox"/> Complex medical/subacute                                 |
|   | <input type="checkbox"/> Neurological/Head Trauma                                 |
|   | <input type="checkbox"/> Pediatric  |
|   | <input type="checkbox"/> Rehabilitation   |
|   | <input type="checkbox"/> Ventilator or Pulmonary                                  |
|   | <input type="checkbox"/> Wound care   |
|   | <input type="checkbox"/> Other _____  |

**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
- University/Academia
- Other \_\_\_\_\_

# of clients your organization cares for daily: \_\_\_\_\_

**Education:**

(Check highest level attained)

- Doctoral degree
- Physician
- Master's 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 \_\_\_\_\_

**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.

**Communication 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 \_\_\_\_\_

Has any licensure board taken **any action** on any of your licenses?  Yes  No

If yes, please explain:

By submission of this membership application, I attest that the information I have provided is true, accurate, and complete. I have not been 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>).

**Membership Categories**

Voting Memberships	National Dues
<p><b>Professional</b></p> <p>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 are accountable for ensuring that quality of care is provided in long term care, residential care, and/or post-acute care setting(s).</p>	\$310
<p><b>Emerging Professional</b></p> <p>Early career professionals: Those persons who are professionally qualified by licensure, certification, education, and/or experience, <b>less than 2 years</b>, to serve as executives or academics in long term care administration, and who are accountable for ensuring that quality of care is provided in long term care, residential care, and/or post-acute care setting(s). <b>*original licensure date required above for eligibility.</b></p>	\$205
Non-voting Memberships	National Dues
<p><b>Administrator Residency/AIT</b></p> <p>Individuals actively enrolled in an AIT internship, or program, in long term care administration and do not meet the qualifications established for Voting Members.</p>	\$45

**Business Affiliate**

\$250

Small business owners/entrepreneurs seeking to connect with leaders in the post-acute and aging services profession, who are committed to the mission of ACHCA and whose connection to ACHCA may enhance business connections and increase brand awareness. **This membership is ideal as a first step before considering the Partnership Program.** [www.achca.org/partnerships](http://www.achca.org/partnerships)

**Payment Information**

**Dues:**

\$ \_\_\_\_\_ Dues from above (Primary Chapter Dues are included)

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

\$ \_\_\_\_\_ Total Remitted

\_\_\_\_\_ I have enclosed a check payable to ACHCA. Check # \_\_\_\_\_

MAIL application & check payment to: ACHCA Membership  
1101 Connecticut Ave NW, Ste. 450, Washington, DC 20036

Once you have everything complete and ready to go, you can submit your ACHCA membership application by e-mail ([membership@achca.org](mailto:membership@achca.org)), or send credit card payment by secure fax (800-561-3148).

**Paying by credit card:**

Please charge my: \_\_\_ American Express \_\_\_ MasterCard \_\_\_ Visa \_\_\_ Discover

Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Name of Cardholder: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_

**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, Authorize.net. The item may appear on your statement as ACHCA.

Questions? Contact: [membership@achca.org](mailto:membership@achca.org) or (800) 561-3148, ext. 703

Thank you for submitting your application. We look forward to having you share the ACHCA Experience with us!