

Referred By: _____

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 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 |

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 _____

- 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 _____

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>Professional</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>	\$350
<p>Emerging Professional</p> <p>Early career professionals: Those persons who are professionally qualified by licensure, certification, education, and/or experience, less than 2 years, 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). *original licensure date required above for eligibility.</p>	\$225
Non-voting Memberships	National Dues
<p>Administrator Residency/AIT</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>	\$50

Retired, Student, and Academic applications begin on page 4

Business Affiliate

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

\$300

Payment Information

Dues:

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

\$ _____ Additional Chapter Dues (\$25.00 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
1300 Piccard Drive, Ste. LL14, Rockville, MD 20850

Once you have everything complete and ready to go, you can submit your ACHCA membership application by e-mail (membership@achca.org), or send credit card payment by secure fax (301) 258-9771.

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 or (800) 561-3148

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

Referred By: _____

Apply online at www.achca.org

*Applicants must hold full-time academic positions in a graduate or undergraduate program in a post-acute/long term care health-related field at an accredited college or university but are not currently practicing as professionals in the field.

Member Profile (*Required information)

Dr. Mr. Ms. Mrs. Sr. Other: _____

*First Name: _____ MI: _____ *Last Name: _____

*College/University Name: (if using college or university address) _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Home Address: _____

City: _____ State: _____ Zip/Postal Code: _____

*Preferred Mailing Address: Home School

*Primary E-mail: _____ Secondary E-mail: _____

Position at College or University: _____

I am (Check all that apply): Full-time Faculty Staff

I teach (Check all that apply): Undergraduate Graduate Other/Continuing Education

If you teach, briefly name or describe the courses you teach, especially those related to post-acute/long term health care. If you serve in an administration role, provide a description of your position.

***How did you hear about ACHCA?**

____ Current Member: _____	____ ACHCA website
____ Friend/Colleague	____ E-mail promotion
____ Facebook/LinkedIn/Twitter	____ NAB
____ LTC Publication	____ Other: _____

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

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.

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>).

ACADEMIC MEMBERSHIP APPLICATION

Academic Membership

This membership best serves individuals that hold full-time academic positions in a graduate or undergraduate program in a post-acute and aging services long term care health-related field at an accredited college or university but are not currently practicing as professionals in the field.

Payment Information

Dues:

Voting Academic Membership	National Dues
Those individuals professionally qualified by licensure, certification, and education seeking Continuing Education (CE) credits, the development of collaborative forums that grant opportunity to develop new course content and teaching methods, and opportunities to meet and network among colleagues who share similar interests.	\$195

Non-Voting Academic Membership	National Dues
Those individuals that maintain a full-time position in an accredited college or university in long term care administration, but are not professionally qualified by licensure, do not seek Continuing Education (CE) credits, and do not meet the qualifications established for Voting Members.	\$140

\$_____ Dues from above (Primary Chapter Dues are included) *As a member of ACHCA, you receive one state chapter membership that is included in your national dues.

\$_____ Additional Chapter Dues (\$25.00 per additional chapter); Name of additional chapter(s):

\$_____ Total Remitted

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

Payment Methods

MAIL application & check payment to: ACHCA Membership, 1300 Piccard Dr, Ste. LL14, Rockville, MD 20850

Once you have everything complete and ready to go, you can submit your ACHCA membership application by e-mail (membership@achca.org), or send credit card payment by secure fax (301) 258-9771.

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. Charges are processed through our merchant services provider, Authorize.net. The item may appear on your statement as ACHCA.

Questions? Contact: membership@achca.org or (800) 561-3148. Thank you for submitting your application. We look forward to having you share the ACHCA Experience with us.



STUDENT MEMBERSHIP APPLICATION

Member Profile (*Required information)

*First Name:

*Primary E-mail:

*Student ID:

*College/University:

*Home Address:

Home Phone:

School Address:

School Phone:

*Preferred Mailing Address: ___ Home ___ School

Education:

(Check highest level attained)

- Master's degree Year in school: 1 2 3 4
- Some graduate work
- Bachelor's degree *Date of Graduation:
- Associate degree
- Diploma in nursing
- High School Diploma

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 ___

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.

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>).

Student Membership

Students **must be currently enrolled full-time in an undergraduate or graduate program in health services administration or related administrative field that leads to a bachelor's degree or higher.** Individuals seeking entry to LTC practice as a nursing home, assisted living, or aging services administrator are eligible for the ACHCA student rate.

Students are **required to provide proof of academic enrollment**, including the name of the college or university, their student identification number, and estimated graduation date on their membership application. Students may submit a photo of their current student ID or tuition bill (confidential information hidden) to membership@achca.org for proof of enrollment.

Referred By: _____

*Last Name:

MI:

Secondary E-mail:

ACHCA Student Chapter (if applicable):

*City/State/Zip:

Mobile:

City/State/Zip:

Non-Voting Membership

National Dues

Student

Those individuals seeking entry to LTC practice as a nursing home, assisted living, or aging services administrator who are enrolled full-time in health-related degree granting, certificate, or diploma program at an accredited college or university not already licensed in another profession, and do not meet the qualifications established for Voting Members.

\$30

Payment Information

Dues:

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

\$ _____ Additional Chapter Dues (\$25.00 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

1300 Piccard Dr, Suite LL14, Rockville, MD 20850

Once you have everything complete and ready to go, you can submit your ACHCA membership application by e-mail (membership@achca.org), or send credit card payment by secure fax (301-258-9771).

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

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



ACHCA

American College of
Health Care Administrators

RETIRED STATUS MEMBERSHIP APPLICATION

Member Profile:

Referred By: _____

ACHCA Member ID (if known) _____ Current Status Member Fellow

Full Name _____ Phone Number _____ Retirement Date _____

Most Recent Title and Employer _____

If you have not recently updated your address within the ACHCA Member Portal, please update your information. If you prefer, call ACHCA Membership at (800) 561-3148 to update over the phone.

Address _____ City _____ State _____ Zip _____

E-mail Address _____

You must meet the following requirements to be eligible for Retired status:

- I am currently an ACHCA Member or Fellow, and have been for at least five years.
- I am retired from healthcare administration.
- I am at least 55 years of age.

By submission of this membership application, I attest that the information I have provided is true, accurate, and complete. In addition, I have read and will continue to adhere to the ACHCA Code of Ethics. (www.achca.org)

RETIRED STATUS MEMBERSHIP APPLICATION

Voting Memberships

National Dues

Retired

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.

\$110

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.

\$90

Payment Information

Dues:

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

\$_____ Additional Chapter Dues (\$25.00 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
1300 Piccard Dr, Suite LL14, Rockville, MD 20850

Once you have everything complete and ready to go, you can submit your ACHCA membership application by e-mail (membership@achca.org), or send credit card payment by secure fax (301-258-9771).

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. Charges are processed through our merchant services provider, Authorize.net. The item may appear on your statement as ACHCA.

Questions? Contact: membership@achca.org or (800) 561-3148

Thank you for submitting your application. We appreciate your leadership in the long term care profession!