ACHCA
American College of Health Care Administrators

MEMBERSHIP APPLICATION

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:

- ❑ Academic
- ❑ Administrator (current)
- ❑ Administrator (retired)
- ❑ Administrator-in-Training
- ❑ Assistant Administrator
- ❑ CEO/COO/President
- ❑ Consultant
- ❑ Dept. Head/Manager
- ❑ Director of Nursing
- ❑ Executive Director
- ❑ Product/Service Provider
- ❑ Vice President/Director
- ❑ Owner
- ❑ Other _____

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 facil

- ❑ Private/For Profit
- ❑ Public/For Profit
- ❑ Not For Profit
- ❑ Government
- ❑ 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_____

Programs (check all that appl

- ❑ 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 _____

# of clients your organization cares for daily: _____

ACHCA
American College of Health Care Administrators

MEMBERSHIP APPLICATION

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
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 are accountable for ensuring that quality of care is provided in long term care, residential care, and/or post-acute care setting(s).	$350
Emerging Professional 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.**	$225
Non-voting Memberships	**National Dues**
Administrator Residency/AIT Individuals actively enrolled in an AIT internship, or program, in long term care administration and do not meet the qualifications established for Voting Members.	Complimentary

Retired, Student, and Academic applications begin on page 4

ACHCA
American College of Health Care Administrators

MEMBERSHIP APPLICATION

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!

ACHCA
American College of Health Care Administrators

ACADEMIC MEMBERSHIP APPLICATION

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 heath care. If you serve in an administration role, provide a description of your position.

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

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

ACHCA
American College of Health Care Administrators

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.

ACHCA
American College of Health Care Administrators

STUDENT MEMBERSHIP APPLICATION

Referred By:_____

Member Profile (*Required information)

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

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

***Student ID:**

***College/University:** **ACHCA Student Chapter** (if applicable):

***Home Address:** ***City/State/Zip:**

Home Phone: Mobile:

School Address: City/State/Zip:

School Phone:

***Preferred Mailing Address:** ___ Home ___ School

Education:

(Check highest level attained)

- ❑ Master's degree
- ❑ Some graduate work
- ❑ Bachelor's degree
- ❑ Associate degree
- ❑ Diploma in nursing
- ❑ High School Diploma

Year in school: ❑ 1 ❑ 2 ❑ 3 ❑ 4

***Date of Graduation:**

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.

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.	Complimentary

Questions? Contact: membership@achca.org

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

www.achca.org

ACHCA
American College of Health Care Administrators

RETIRED STATUS
MEMBERSHIP APPLICATION

Member Profile:

Referred By: _____

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

_____
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)

ACHCA
American College of Health Care Administrators

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!