**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):**

- 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 facility:**

- 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

**# of clients your organization cares for daily:**

**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)
- Complex medical/subacute
- Neurological/Head Trauma
- Pediatric
- Rehabilitation
- Ventilator or Pulmonary
- Wound care
- Other

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Updated on 2/2/2024
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

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

<table>
<thead>
<tr>
<th>Voting Memberships</th>
<th>National Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional</strong></td>
<td>$310</td>
</tr>
<tr>
<td>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).</td>
<td></td>
</tr>
</tbody>
</table>

| **Emerging Professional**          | $205          |
| 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.* |

<table>
<thead>
<tr>
<th>Non-voting Memberships</th>
<th>National Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administrator Residency/AIT</strong></td>
<td>$45</td>
</tr>
<tr>
<td>Individuals actively enrolled in an AIT internship, or program, in long term care administration and do not meet the qualifications established for Voting Members.</td>
<td></td>
</tr>
</tbody>
</table>

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Updated on 2/2/2024
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

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), 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 or (800) 561-3148, ext. 703

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