MEMBERSHIP APPLICATION

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: _______

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

www.achca.org

Updated on 6/26/2024
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
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

<table>
<thead>
<tr>
<th></th>
<th>Voting Memberships</th>
<th>National Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>$310</td>
<td></td>
</tr>
</tbody>
</table>
| Emerging Professional| $205               | (original licensure date required above for eligibility.)

<table>
<thead>
<tr>
<th></th>
<th>Non-voting Memberships</th>
<th>National Dues</th>
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<tbody>
<tr>
<td>Administrator Residency/AIT</td>
<td>$45</td>
<td></td>
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</table>

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](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  
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!
ACADEMIC MEMBERSHIP APPLICATION

*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:**

<table>
<thead>
<tr>
<th>Voting Academic Membership</th>
<th>National Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>$175</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Voting Academic Membership</th>
<th>National Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>$125</td>
</tr>
</tbody>
</table>

$________ 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 ($30.00 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.

[www.achca.org](http://www.achca.org)
**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:**
  - **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.

**Payment Information**

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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
Member Profile:

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)
Voting Memberships

<table>
<thead>
<tr>
<th></th>
<th>National Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired</td>
<td>$100</td>
</tr>
<tr>
<td>Retired Fellow</td>
<td>$80</td>
</tr>
</tbody>
</table>

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.

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.

Payment Information

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$_______ Additional Chapter Dues ($30.00 per additional chapter); Name of additional chapter(s): $_______ Total Remitted

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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!