ACHCA
American College of Health Care Administrators

Professional 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: _____

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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

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.

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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!