American College of Health Care Administrators
Membership Application/Renewal Form
12-Month Membership Period

Updated 12-3-13

Contact Information (*Required items)

__Dr. __ Mr. __Ms. __ Mrs. __ Sr. __Rev. __Other
Name: _____ Credentials:_____
***Primary Email**: _____
Secondary Email: _____
Title: _____
***Facility/Company/School**: _____
National Provider Identification Number (NPI): _____
***Home Address**:_____
***City/State/Zip**: _____
Home Phone: (___)_____ Mobile: (___)_____
***Parent Corporation Name**: _____
Number of Sites:_____ Total Beds: _____
Business/School Address: _____
City/State/Zip: _____
Business/School Phone: (___)_____Fax: (___)_____
Preferred Mailing Address: ___ Home ___ Office/School

***How did you hear about ACHCA?___Current Member (list below)**
___ Friend/Colleague ___ ACHCA website ___ NAB
___Facebook/LinkedIn/Twitter ___ Email promotion
___ LTC publication ___Other_____

Referred by: Name _____ Chapter _____

Demographic Data (*Required items)

Collection of this data will be used for statistical and survey purposes to improve and/or create programs and services to better serve you.

***Age: Birth Year _____**

Gender: ___Male ___Female

Race: ____Black or African American ____White
____Hispanic or Latino ____American Indian/Alaska Native
____ Pacific Islander ____Arabic ____ Asian
_____Other_____

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
- ❑ Student
- ❑ Product/Service Provider
- ❑ Vice President/Director
- ❑ Owner
- ❑ Other _____

Education:
(Check highest level attained)

- ❑ Doctoral degree
- ❑ Physician
- ❑ Masters 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 _____

Students (if applicable):
Year in school: ❑ 1 ❑ 2 ❑ 3 ❑4
Expected Graduation Date: _____

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: _____
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
- ❑ Other_____

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) (check all that apply)
  - □ Complex medical/subacute
  - □ Neurological/Head Trauma
  - □ Pediatric
  - □ Rehabilitation
  - □ Ventilator or Pulmonary
  - □ Wound care
  - □ Other _____
- ❑ University/Academia

# of clients your organization cares for daily:_____

Communications Options (Required)

1. 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.

American College of Health Care Administrators
Membership Application/Renewal Form
12-Month Membership Period
Updated 12-3-13

Voting Memberships	Description	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).	**$310**
Emerging Professional	Same as above licensed or professional qualified less than 2 years.	**$205**
Retired Member	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.	**$100**
Retired Fellow	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.	**$80**
Non-voting Memberships	**Description**	**National Dues**
Associate	Those individuals who have an interest in long-term health care quality and administration, but do not meet the qualifications established for Voting Members.	**$205**
Collegiate/AIT*	I Individuals seeking entry to LTC practice as a nursing home, assisted living, or aging services administrator who are enrolled in health-related degree granting, certificate, or diploma program at an accredited college or university, or actively enrolled in an AIT/internship in long term care administration, not already licensed in another profession, and do not meet the qualifications established for Voting Members.	**$47**
Business Affiliate	Company membership providing representatives the opportunity to network with long term care leaders at national and state chapter activities.	**$520**
Fees	**Description**	**Amount**
Application Fee	Applies to all new member applications. Required for all renewals received after 30 days of membership expiration date. Waived for Collegiate/AIT members.	**$25**
Lapsed Fellow Renewal Fee	For ACHCA Fellows whose membership has expired >60 days, Fellow status can be reinstated by submitting the abbreviated Fellow application located at www.achca.org/development and paying the Lapsed Fellow Renewal and Membership application fees. The Fellow credential lapses if not current 60 days post membership expiration.	**$250**

*Requires proof of academic enrollment (i.e. current student ID and class schedule or tuition bill) or a letter from an AIT preceptor on company letterhead.

A. Dues

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

$_____ *Additional* Chapter Dues @ $30.00 per additional chapter; Name of additional chapter(s):_____

$ 25.00 Application fee (see description above)

$_____ Lapsed Fellow Renewal Fee (see description above)

$_____ Total Dues (A)

B. Donation to The Academy of Long Term Care Leadership and Development (tax deductible)

Enter amount:

$_____ Up to $99 Academy Friend

$_____ $100-$249 Academy Supporter

$_____ $250-$499 Academy Benefactor

$_____ $500-$999 Academy Pace Setter

$_____ $1,000-$2,499 Academy Champion

$_____ $2,500-$4,999 Academy Patron

$_____ $5,000+ Academy Chair's Circle

$_____ Fellow Promise: □ $1,000/year for 4 years; □ $500/year for 4 years; □ $250/year for 4 years;
□ $_____ (other amount) /year for 4 years

$_____ **Total Academy Donations (B)**

C. Donations (tax deductible) *For more information on donation options, including Legacy Giving, visit www.achca.org.*

Enter Amount:

$ _____ ACHCA Unrestricted donation/Fund Drive donation
$_____ Student Development (restricted fund for Student/AIT activities)
$_____ Richard L. Thorpe Fellowship
$_____ Sr. Joan Cassidy & Michael Cuseo Diversity Endowment Fund
$_____ W. Phillip McConnell Student Scholarship Fund
$_____ Total Donations (C)

D. Total Payment

$_____ A. Dues
$_____ B. Academy Donations
$_____ C. Donations
$_____ Total Remitted

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

_____ Please charge my: ___American Express ___MasterCard ___Visa ___Discover

Account Number: _____Expiration Date: _____
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, PayPal. The item may appear on your statement as PAYPAL ACHCA or PURCHASE AMERICANCOL.

By submission of this membership application, I attest that I have not had a professional license suspended, 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).

Dues are payable upon receipt in U.S. Funds, drawn on a U.S. bank. For U.S. citizens only: ACHCA membership dues are not deductible as a charitable contribution for U.S. federal income tax purposes, but may be deductible as a business expense under section 162 of the Internal Revenue Code as an "ordinary and necessary business expense.". Please consult your tax professional for more information. Contributions of gifts to ACHCA are deductible as charitable contributions for federal income tax purposes. FEIN: 36-2637617

FAX 3-page application with credit card payment to our secure fax at 866-874-1585
MAIL application & check payment to ACHCA Membership, PO Box 75060, Baltimore, MD 21275-5060
Questions? Contact: membership@achca.org or (202) 536-5120