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

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 ________

# 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.

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 ________

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
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Other

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## Voting Memberships

<table>
<thead>
<tr>
<th>Description</th>
<th>National Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>$310</td>
</tr>
<tr>
<td>Emerging Professional</td>
<td>$205</td>
</tr>
<tr>
<td>Retired Member</td>
<td>$100</td>
</tr>
<tr>
<td>Retired Fellow</td>
<td>$80</td>
</tr>
</tbody>
</table>

## Non-voting Memberships

<table>
<thead>
<tr>
<th>Description</th>
<th>National Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>$205</td>
</tr>
<tr>
<td>Collegiate/AIT*</td>
<td>$47</td>
</tr>
<tr>
<td>Business Affiliate</td>
<td>$520</td>
</tr>
</tbody>
</table>

## Fees

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Fee</td>
<td>$25</td>
</tr>
<tr>
<td>Lapsed Fellow Renewal Fee</td>
<td>$250</td>
</tr>
</tbody>
</table>

*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): ________________
- $_____ 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