CAHCF/CCAL
Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

2018 CAHCF Membership Agreement
Assisted Living

Please fill out the information portion of this form and <u>sign at the bottom</u> and return it to us via fax or email, so that we may enroll your facility as a Member in AHCA/NCAL and CAHCF/CCAL.

Number of Assisted Living Beds: _____

Profit: _____ Non-Profit: _____

Facility Information:

Facility Name: _____

Administrator/Executive Director: _____

Address: _____

City, State, Zip: _____

County: _____

Email Address: _____

Facility's Website : _____

Telephone Number: _____ Fax Number: _____

Ownership/Operating Information:

Owner/Parent Company _____

Address: _____

City, State, Zip _____

Contact Person: _____

Telephone Number: _____ Fax Number: _____

Email Address _____

Has the ownership of this facility changed within the last 12 months? _____

If yes, the date that ownership changed: _____

Name of previous owner: _____

Management Company Information: (If Applicable)

Management Company Name: _____

Address: _____

City, State, Zip _____

Contact Person: _____

Telephone Number: _____ Fax Number: _____

Email Address _____

Has the Management Company of this facility changed within the last 12 months? _____ **Yes** _____ **No**

If yes, the date that the Management Company changed: _____

Name of previous Management Company: _____

Regional Contact: (If Applicable)

Regional Contact Name: _____

Title: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Administration Information:

Director of Nursing/ RN Supervisor (SALSA): _____ Email: _____

Director of Staff Development: _____ Email: _____

Director of Admissions: _____ Email: _____

Dues/Seminar Invoices:

Send CAHCF/CCAL Dues Invoices to: ☐ Facility ☐ Owner ☐ Corporate Office

Dues Payment Will Be Paid: ☐ Monthly ☐ In Full

Invoices to be sent via: _____ **Mail** _____ **Email**

Contact: _____

Company Name: _____

Address: _____

City, State, Zip _____

Telephone Number: _____ Fax Number: _____

Email Address _____

Signing indicates that you agree to pay all membership dues applicable to your facility based on the total number of your licensed beds for the calendar year 2019 in accordance with the dues payment plan selected above and that you agree to abide by the Bylaws and policies of the Association.

Membership Benefits:
I understand that membership benefits are only to be used by the employees of the facility and that any misuse of membership rights and benefits may result in membership termination.

Dues Payments:
Dues payments, contributions, or gifts to CAHCF/CCAL are not tax deductible as charitable contributions. However, dues payments may be deductible as ordinary and necessary business expenses subject to tax restrictions imposed on the deductibility of lobbying expenditures. The percentage of the lobbying expense, that can't be deducted is on your monthly invoices.

Consent to Receive Notices:
I understand that by providing my mailing address, email address, telephone number and fax number, I consent to receive communications sent by or on behalf of the Connecticut Association of Health Care Facilities/Connecticut Center for Assisted Living, and its respective subsidiaries and affiliates, via mail, email, telephone, or FAX. However, be assured that your information will never be sold or given away.

Membership Category:
Any Nursing, Assisted Living or Residential Care Facility licensed in the state of Connecticut shall be eligible for Membership in this Association.

Termination Of Membership:

☐ By checking this box, you agree to pay your membership dues and note that cancellation must be made in writing thirty days (30) prior to the cancellation effective date. Termination does not reduce or forgive any debt owed at the time of termination.

Authorized Signature: _____

Print Authorized Signature: _____

Title: _____

Date: _____

Please FAX forms to 860-290-9478 or EMAIL scanned forms to: amanning@cahcf.org