

IMPORTANT!

2019 MEMBERSHIP AGREEMENT FORM

**TO: CAHCF MEMBERS**

**FROM: ADRIANA MANNING**

**DATE: DECEMBER 18, 2018**

Please find attached the 2019 CAHCF/CCAL Membership Form, to remain a member of CAHCF/CCAL we must receive the completed and signed form by January 7, 2019.

CAHCF/CCAL will be updating our website to include online registration and payment system, it is important that we have the most-up-to-date information regarding our Members.

The updated information will also be needed for our 2019 Membership Guide, please make sure that you list all of the services that you offer at your facilities. The Membership Directory is sent to: Hospital Discharge Planners, Local and State Officials and State Agencies.

PLEASE NOTE: A majority of our communications are sent via email it is imperative that we have a valid email address for your facility on file, if your facility does not have an email address, please notify us so that we can add you to the fax distribution list.

*Please be sure to fill out all sections of this form.*

If you have any questions please email me at [amanning@cahcf.org](mailto:amanning@cahcf.org) or call me at 860-290-9424.

**FAX forms to 860-290-9478 or**

**EMAIL to amanning@cahcf.org**

**by JANUARY 7, 2019**



2019 CAHCF Membership Agreement

**Licensure Information:**

Number of Licensed Beds:

Are you Not-For Profit:

**What services does your facility offer? This information will be published in the directory.**

Dementia Care  DD Services Therapy Services Secured Dementia Unit

TPN  Ventilator Pet Therapy Brain Injury Care

IV Services  Hospice Care Short-Term Rehab Out-Patient Rehab

❑ Other: Click here to enter text.

**Facility Information:**

|  |  |
| --- | --- |
| Facility Name: | Click here to enter text. |
| Administrator: | Click here to enter text. |
| Address: | Click here to enter text. |
| City, State, Zip: | Click here to enter text. |
| County: | Click here to enter text. |
| Email Address: | Click here to enter text. |
| Facility’s Website : | Click here to enter text. |
| Telephone Number: | Click here to enter text. Fax Number: Click here to enter text. |

**Ownership/Operating Information:**

|  |  |  |
| --- | --- | --- |
| Owner/Parent Company | Click here to enter text. | |
| Address: | Click here to enter text. | |
| City, State, Zip | Click here to enter text. | |
| Contact Person: | Click here to enter text. | |
| Telephone Number: | Click here to enter text. Fax Number: Click here to enter text. | |
| Email Address | Click here to enter text. | |
| Has the ownership of this facility changed within the last 12 months? | | Click here to enter text. |
| If yes, the date that ownership changed: | Click here to enter text. | |
| Name of previous owner: | Click here to enter text. | |

**Management Company Information: (If Applicable)**

|  |  |  |
| --- | --- | --- |
| Management Company Name: | Click here to enter text. | |
| Address: | Click here to enter text. | |
| City, State, Zip | Click here to enter text. | |
| Contact Person: | Click here to enter text. | |
| Telephone Number: | Click here to enter text. Fax Number: Click here to enter text. | |
| 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: | Click here to enter text. | |
| Name of previous Management Company: | Click here to enter text. | |

**Regional Contact: (If Applicable)**

|  |  |
| --- | --- |
| Regional Contact Name: | Click here to enter text. |
| Title: | Click here to enter text. |
| Address: | Click here to enter text. |
| City, State, Zip: | Click here to enter text. |
| Telephone Number: | Click here to enter text. Fax Number: Click here to enter text. |
| Email Address: |  |

**Administration Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Director of Nurses: | Click here to enter text. | Email: | Click here to enter text. |
| Director of Staff Development: | Click here to enter text. | Email: | Click here to enter text. |
| Director of Admissions: | Click here to enter text. | Email: | Click here to enter text. |

**Dues/Seminar Invoices:**

Send CAHCF Dues Invoices to:  Facility  Owner  Corporate Office

Send Seminar Invoices to:  Facility  Owner  Corporate Office

Dues Payment Will Be Paid:  Monthly  In Full By February 1, 2019

|  |  |
| --- | --- |
| Invoices to be sent via: | **Mail  Email** |
| Contact: | Click here to enter text. |
| Company Name: | Click here to enter text. |
| Address: | Click here to enter text. |
| City, State, Zip | Click here to enter text. |
| Telephone Number: | Click here to enter text. Fax Number: Click here to enter text. |
| Email Address | Click here to enter text. |

\*\*\*Please fill out the information portion of this agreement, sign at the bottom and return it to stay an active member of CAHCF.

**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.

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.**

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:**

Membership shall consist of post-acute care providers, regardless of description or classification, licensed by or registered with the State of Connecticut. For the purposes of these bylaws, any institution or agency licensed pursuant to Section 19a-490 of the Connecticut General Statutes or registered as a “Managed Residential Community” pursuant to Section 19a-694 of the Connecticut General Statutes shall be called a "provider."

**Termination Of Membership:**

To terminate your membership you must notify CAHCF in writing at 30 days prior to termination. Termination does not reduce or forgive any debt owed at the time of termination.

|  |  |
| --- | --- |
| **Authorized Signature:** | Click here to enter text. |
| **Print Authorized Signature:** | Click here to enter text. |
| **Title:** | Click here to enter text. |
| **Date:** | Click here to enter text. |

**Please FAX forms to 860-290-9478 or EMAIL forms to** [**amanning@cahcf.org**](mailto:amanning@cahcf.org) **by January 7, 2019**

**Please Note:**

* Information collected on this form will be included in the 2019 CAHCF Membership Directory. The information will be submitted for print in February, without your updated information, it will be necessary to use the information provided to us last year.
* CAHCF/CCAL will be implementing an online registration and payment system, therefore, it is imperative that we have the correct information for each of our member facilities.