

2020 CAHCF Membership Agreement

Assisted Living

Please fill out the information portion of this form and sign at the bottom 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: | Click here to enter text. |
| Administrator/Executive Director: | 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: | Click here to enter text. | |
| 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: | Click here to enter text. |

**Administration Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Director of Nursing/  RN Supervisor (SALSA): | 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/CCAL Dues Invoices to:  Facility  Owner  Corporate Office

Dues Payment Will Be Paid:  Monthly  In Full

|  |  |
| --- | --- |
| 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. |

**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 2020** 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 COMPLETE AND RETURN, EITHER BY FAX 860-290-9478 or by EMAIL** [**amanning@cahcf.org**](mailto:amanning@cahcf.org)

**Please Note:**

* Information collected on this form will be included in the 2020 CAHCF/CCAL 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 members.**