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

2021 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: ____

Facility Information:

Facility Name: ____

Administrator: ____

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 Nurses: ______________________ Email: ______________________

Director of Staff Development: ______________________ Email: ______________________

Director of Admissions: ______________________ Email: ______________________

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, 2017

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

Contact: ______________________

Company Name: ______________________

Address: ______________________

City, State, Zip ______________________

Telephone Number: ______________________ Fax Number: ______________________

Email Address ______________________

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 2021 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 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, 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 or Residential Care Facility licensed in the state of Connecticut shall be eligible for Membership in this Association.

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: ______________________________

Print Authorized Signature: ______________________________

Title: ______________________________

Date: ______________________________

PLEASE COMPLETE AND RETURN, EITHER BY FAX TO 860-290-9478 OR EMAIL amanning@cahcf.org by January 29, 2021

Please Note:

- Information collected on this form will be included in the 2021 CAHCF/CCAL Membership Directory, without your updated information, it will be necessary to use the information provided to us last year.
- CAHCF/CCAL has implemented an online registration, payment and CEU system, your account is tied to your email address. Therefore, it is imperative that we have the correct information for each of our members.