

## 2023 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.

- |  |                                       |   |  |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Dementia Care | <input type="checkbox"/> DD Services  | <input type="checkbox"/> Therapy Services | <input type="checkbox"/> Secured Dementia Unit |
| <input type="checkbox"/> TPN           | <input type="checkbox"/> Ventilator   | <input type="checkbox"/> Pet Therapy      | <input type="checkbox"/> Brain Injury Care     |
| <input type="checkbox"/> IV Services   | <input type="checkbox"/> Hospice Care | <input type="checkbox"/> Short-Term Rehab | <input type="checkbox"/> Out-Patient Rehab     |
| <input type="checkbox"/> 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:**

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/CCAL.**

**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 2023 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/Connecticut Center for Assisted Living, and its respective subsidiaries and affiliates. 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](mailto:amanning@cahcf.org)**

**Please Note:**

- Information collected on this form will be included in the 2023 CAHCF 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.