**NORTH CAROLINA HEALTH CARE FACILITIES ASSOCIATION**
**5109 BUR OAK CIRCLE**
**RALEIGH, NC 27612**
**(919) 782-3827**
**(919) 787-8418 FAX**

# APPLICATION FOR MEMBERSHIP

Member Account Number:_____ (for office) Date:_____

Facility Name_____

Mailing Address:_____

_____

Shipping Address (If different):_____

_____

Name of Administrator: _____

Telephone Number:_____ Fax Number:_____

Email Number: _____

Medicare Provider Number_____Medicaid Provider Number_____

County:_____

Year Organized:_____

Names of Governing Body (Board of Directors, Board of Trustees), Owners and/or Corporate Officers:

_____

_____

_____

Does the Governing Body/Owners operate or have an interest in other facilities in this state? If so, list the names of these facilities:

_____

_____

_____

## TYPE OF OWNERSHIP (Please Check One)

____ Independent Owner: A nursing facility which shares common ownership, control or management with four or fewer other nursing facilities shall be considered an independently-owned provider. (If a company owns, controls, or manages five or fewer nursing facilities, regardless in which state those nursing facilities exist, each nursing facility would be considered an independently-owned nursing facility.)

____ National Multi-Facility: Any nursing facility which shares common ownership, control or management of skilled nursing facilities in two or more states. (If a company owns, controls or manages six or more nursing facilities and at least one of those facilities operates in a state other than North Carolina, each nursing facility would be considered a national multi-facility provider.)

_____ Multi-Facility: Any nursing facility which shares common ownership, control or management with five or more other facilities, whether such facilities are within or out of the state of North Carolina. (If a company owns, controls, or manages six or more nursing facilities, regardless in which state those nursing facilities exist, each nursing facility would be considered a multi-facility provider.)

____ Hospital-Affiliated: A facility that shares common ownership, control or management with a hospital.

____ Other: Please provide details _____

Please check one:

_____ For Profit

_____ Not for Profit

Owner/Corporation Name: _____

Owner/Corporation Address: _____

Owner/Corporation Telephone Number:_____

Has the facility previously been a member of the Association?_____

Date facility was licensed:_____

License Number:_____

If under construction, anticipated Date of Licensure_____

Number of Nursing Care Beds (NA):_____ Domiciliary Care (HA):_____ Retirement:_____ Other:_____

Special Care Unit:_____

Name of Director of Nursing:_____

Additional Comments:_____

_____

On behalf of the facility named below, I hereby apply for membership in the North Carolina Health Care Facilities Association, and the American Health Care Association. I agree to comply with all rules and regulations as set forth in the Bylaws of the Association, including the requirement to pay annual membership dues owed by the facility in accordance with Section 3 of Article V of the Bylaws. I further agree to pay all other debts owed or owing in the future to the Association by the facility named below.

By:_____ (Signature)

_____(Title)

_____(Date)

Name of Facility_____

Mail this application to:
Attention: Karen Lennon
North Carolina Health Care Facilities Association
5109 Bur Oak Circle
Raleigh, NC 27612