

West Virginia HEALTH CARE Association



Membership Application

I hereby apply for membership in the West Virginia Health Care Association. If accepted, I will abide by its bylaws and code of ethics, and pay the established dues. My application fee of \$50.00 is enclosed, with the understanding that upon approval of this application, the \$50.00 will be applied to my dues.

Name of Facility _____

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Administrator: _____

Email address: _____

_____ Proprietary _____ Non-proprietary

Number of Licensed beds:	_____	Dually Certified Beds
	_____	Medicaid Only Beds
	_____	Medicare Only Beds
	_____	Swing Beds
	_____	Private Pay Beds
	_____	Assisted Living Residence Beds
	_____	Residential Care Community Beds
	_____	Home Health
	_____	TOTAL BEDS

Name of Owner/Owners: _____

Number of other facilities owned in West Virginia by the same owner(s): _____

Membership in the American Health Care Association is required of all WVHCA members. AHCA and WVHCA dues are payable in advance either monthly, quarterly or annually (per member preference). Members who elect to pay monthly will be billed monthly. Copies of the WVHCA and AHCA dues structure are enclosed with this application.

DATE: _____ Signature of Owner
or Administrator: _____