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E-mail is used for delivery of information to members. Please keep NHCA/NALA informed of current e-mail addresses!

For NHCA/NALA Office Use:
EXCEL
ACCTNG
NHCADB
AHCADB

FACILITY MEMBERSHIP APPLICATION

Name of Facility Date
Address City Zip
Facility Phone (including area code) Fax
E-mail Web Site

Membership Application for:
Number of Licensed Beds:
Type of Operation:
Legislative District:

Name of Administrator
Name of Alternate Designated Representative
Name and Address of Owner
Name and Address of Management Corporation

MEMBERSHIP DUES -- (Complete the "Dues Payment Plan" on the other side of this application form.)
Dues include membership in the Nebraska Health Care Association and/or Nebraska Assisted Living Association...

RESPONSIBILITIES
The undersigned hereby agrees to abide by the Code of Ethics and policies of the Nebraska Health Care Association. Member applicants are subject to approval by the Association's Board of Directors.

APPLICANT:
Signed Date
Title

Contributions or gifts to the Nebraska Health Care Association and/or Nebraska Assisted Living Association are not deductible as charitable contributions for Federal income tax purposes.



An Affiliate of the American Health Care Association

ARTICLE V. TERMINATION OF MEMBERSHIP

Section 1. Voluntary Termination. Any member may voluntarily terminate its membership by notice in writing addressed to the Secretary of the Nebraska Health Care Association at the Nebraska Health Care Association's principal place of business. The termination will be effective on the date specified in the notice. If no effective date is given, it will be effective on the date received by the Nebraska Health Care Association. Membership automatically renews each year unless a member voluntarily terminates as provided in this section or is involuntarily terminated. Voluntary termination shall not reduce or forgive any debt, including unpaid installments of annual dues, owed by the member to the Nebraska Health Care Association, nor shall it entitle the member to a refund of dues paid.

Section 2. Involuntary Termination. Except as otherwise provided in this Article with regard to unmet financial obligations, the rights or membership of a member shall not be suspended or terminated except for good cause and until the subject member has received a hearing on the allegations of good cause after reasonable notice. Termination under this Article shall not reduce or forgive any debt, including unpaid installments of annual dues, owed by the member to the Nebraska Health Care Association, but shall entitle the member to a pro rata refund of annual dues, with credits to the Nebraska Health Care Association for any dues not paid.

A. Good Cause. Good cause for termination shall include each of the following: failure to meet or continue to meet the qualifications for membership set forth in the Articles of Incorporation or Bylaws; failure or refusal to abide by any rule or regulation of the Nebraska Health Care Association adopted by the Board of Directors or the membership; or loss of Nebraska license based upon the failure to meet Nebraska licensure requirements.

B. Hearing Procedures. Hearing procedures shall be established by resolution of the Board of Directors. They shall provide the affected member with reasonable notice of the allegations of the complaint and a right to be heard before a decision is made to suspend or terminate any membership rights.

Section 3. Financial Obligations. Any member who is not in good standing shall be automatically suspended from voting and all other rights and privileges of the Nebraska Health Care Association until such time as good standing is restored. Good standing shall mean that all dues or other amounts owed Nebraska Health Care Association are paid or that the member is current in any dues or other financial obligation payment plan authorized by the Board of Directors. Good standing shall be restored either by 1) paying all amounts due in full, 2) becoming and remaining current on any payment plan approved by the Board of Directors, or 3) a determination of the Board of Directors or by a court of competent jurisdiction that the member, in fact, is in good standing.

DUES PAYMENT PLAN

DUES FOR THE FACILITY INDICATED ON THE OTHER SIDE OF THIS APPLICATION FORM WILL BE PAID ACCORDING TO THE PAYMENT PLAN CHECKED:

- | | |
|---|---|
| <input type="checkbox"/> ANNUAL | Facilities that pay annual dues in full by January 15th will receive a 2.5% DISCOUNT. |
| <input type="checkbox"/> SEMI-ANNUAL | Dues are payable by the first of each calendar semi-annual period. |
| <input type="checkbox"/> QUARTERLY | Dues are payable by the first of each calendar quarter. |
| <input type="checkbox"/> MONTHLY | Dues are payable by the first of each month. |



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IF APPLICABLE, Please identify the individuals by name who fill THESE ROLES IN YOUR FACILITY -- Please type or print clearly!

Nursing Facility Staff:

Director of Nursing: _____
Director of Nursing E-mail: _____
Social Services Director: _____
Social Services Director E-mail: _____
Activities Director: _____
Activities Director E-mail: _____
Dietary Manager: _____
Dietary Manager E-mail: _____
Inservice Director: _____
Medical Director (Full Name): _____
Marketing Coordinator: _____

Assisted Living Facility Staff:

Resident Services Director: _____
Resident Services Director E-mail: _____
RN Staff Nurse: _____
LPN Staff Nurse: _____
Social Director: _____
Dietary Manager: _____

CHECKLIST OF SERVICES PROVIDED BY YOUR FACILITY

Place a check mark beside the services your facility provides.

(A definition of services is printed on the back of this page.)

CERTIFICATION:

____ Nursing Facility Medicare Certification
____ Nursing Facility Medicaid Certification
____ Assisted Living Medicaid Certification

____ Meals - Congregate
____ Meals - Home Delivered
____ Medical Equipment/Supplies (DME)
____ Personal Care Aides
____ Personal Emergency Response Systems
____ Rehabilitation Services (PT, OT, SP)

SERVICES:

____ Bilingual/Multilingual Staff
Languages Spoken: _____
____ Case Management
____ Children with Disabilities Services
____ Chore Services
____ Day Care -- Adult
____ Day Care -- Child
____ Diagnostic Services
____ Health Clinic
____ Home Health
____ Homemaker Services
____ Hospice
____ Information and Referral

____ Respite
____ Special Care Unit
Type of Unit: _____
Special Care Unit Licensed as: Nursing Facility
 Assisted Living Facility
____ Subacute Care
____ Transportation
____ Other: _____

Definitions of Services

Bilingual/Multilingual Staff: Staff who are using or able to use two or more languages with equal fluency.

Case Management (Service Coordination): The process of assessment, care plan development, referral, coordination of services, and evaluation of the plan which results in a system of support based on client/family needs, priorities, and goals. May be available to all residents in a community.

Children with Disabilities Services: A wide array of services specifically for children with disabilities which may include but is not limited to respite care, therapy services, before and after school care, and/or transportation.

Chore Services: Services needed inside or outside of a private home to maintain a safe, healthy structure. May include home modifications or physical adaptations which support access and independence.

Day Care, Adult: A program designed to meet the needs of adults in a community with functional or cognitive disabilities in a protective setting during any part of the day but less than 24 hours.

Day Care, Child: A program designed to enhance the physical, social, and cognitive skills of the healthy child in a protective environment during any part of the day but less than 24 hours.

Diagnostic Services: Such as laboratory or x-ray services which may be accessed by any community resident.

Health Clinic: A service located within a building which provides advice, counseling, diagnosis, treatment, surgery, care, or services relating to the preservation or maintenance of health and provided on an outpatient basis and available to all community residents.

Home Health Care: An array of services intended to foster health and independence in one's own home including but not limited to intermittent, skilled nursing care; therapy services; and homemaker/home health aide care.

Homemaker Services: Services inside a private home needed to maintain a healthy living environment. May include cleaning, laundry, meal preparation, child care, and other services. Does not include personal care.

Hospice: A program of palliative care to patients and their families in the last six months of a terminal illness and during the bereavement period. May be in the facility with contracted services from an outside vendor, or the facility may offer its own hospice service to residents of the facility and community at large.

Information and Referral: Communicating all service options in writing and/or verbally to a client and/or family upon request. May be available to all residents in a community.

Meals, Congregate: Nutritional services provided in a group setting and open to community residents.

Meals, Home Delivered: Nutritional services which provide a prepared meal delivered to a private home in the community.

Medical Equipment and Supplies (DME): The rental or sale of medical equipment and/or supplies available to any community resident.

Personal Care Aide: An individual who assists with activities of daily living such as personal hygiene, eating, medications, and housekeeping. May be available to residents in a private home (not a facility).

Personal Emergency Response System: A piece of equipment that is worn on the person that, when activated by the client, initiates an emergency response system. Is not a staff call system or an elopement prevention system. May be available to community residents.

Rehabilitation Services: An array of therapies provided on an inpatient or outpatient basis by or under the guidance of a licensed professional. May include physical therapy, occupational therapy, speech pathology, or respiratory therapy. May be available to all residents in a community.

Respite: Any support options provided on a short-term basis for the purpose of providing relief to those who care for someone with special needs. May be provided in a facility or in the home.

Special Care Unit: A distinct part of a facility which specializes in the care of individuals with a specific type of medical diagnosis or functional disability.

Subacute Care: Comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process. It is goal-oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments.

Transportation: The provision of transportation of residents which enables them access to community services and resources. May include escort service. May be available to all community residents.



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NHCA/NALA MEMBERSHIP DUES POLICY

DRAFTED BY: NHCA EXECUTIVE COMMITTEE

APPROVED BY BOARD OF DIRECTORS: NOVEMBER 18, 2011

EFFECTIVE DATE: JANUARY 1, 2012

Facility Membership is an Annual Obligation Automatically Renewed Unless Terminated in Writing by December 15, 2011, for 2012 Membership.

NHCA DUES ASSESSMENT:

<u>NHCA DUES</u>	<u>AHCA DUES</u>	<u>TOTAL DUES</u>
(SNF/NF/ICF-MR or HospSwing Beds)	(SNF/NF/ICF-MR or HospSwing Beds)	(SNF/NF/ICF-MR or HospSwing Beds)
\$31.90 Per Licensed Bed	\$20.60 Per Licensed Bed	\$52.50 Per Licensed Bed

Dues for membership are \$31.90 per licensed bed for NHCA and \$20.60 per licensed bed for AHCA. Your per-bed dues will be \$52.50 for the year 2012. (See maximum and minimum dues explained below.)

DUES FORMULA FOR NURSING FACILITIES (SNF/NF/ICF-MR or HospSwing) WITH 4 TO 200 BEDS:
\$52.50 (NHCA dues plus AHCA dues) x Total Number of Licensed Beds (4 beds up to a maximum of 200 beds)

NALA DUES ASSESSMENT:

<u>NALA DUES</u>	<u>AHCA (NCAL) DUES</u>	<u>TOTAL DUES</u>
(Assisted Living Beds)	(Assisted Living Beds)	(Assisted Living Beds)
\$19.75 Per Licensed Bed	\$10.50 Per Licensed Bed	\$30.25 Per Licensed Bed

Dues for membership are \$19.75 per licensed bed for NALA and \$10.50 per licensed bed for NCAL. Your per-bed dues will be \$30.25 for the year 2012. (See maximum and minimum dues explained below.)

DUES FORMULA FOR ASSISTED LIVING FACILITIES WITH 6 TO 200 BEDS:
\$30.25 (NALA dues plus AHCA dues) x Total Number of Licensed Beds (6 beds up to a maximum of 200 beds)

MAXIMUM: For NHCA, NALA and AHCA dues assessments, maximum bed limits are as follows: Nursing Facilities – 200 bed maximum; Assisted Living Facilities – 200 bed maximum. If a facility has both Nursing Facility beds (SNF/NF/ICF-MR or Hospital-Swing) and Assisted Living beds (AL), this maximum bed number is applied to each of the two categories.

MINIMUM: The NHCA and NALA dues assessments each require a minimum of \$100.00. Facilities that do not meet the minimum requirement of \$100.00 per facility for NHCA and/or NALA dues will be billed in accordance with the appropriate formula listed below. Nursing Facilities (SNF/NF/ICF-MR or HospSwing) with 3 beds or less will need to use the Nursing Facilities formula below. Assisted Living Facilities with 5 beds or less will need to use the Assisted Living formula below.

DUES FORMULA FOR NURSING FACILITIES (SNF/NF/ICF-MR or HospSwing) WITH 3 BEDS OR LESS:
[\$100.00 (NHCA Minimum)] + [\$20.60 (AHCA Nursing Facility Dues) x Total Number of Licensed Beds]

DUES FORMULA FOR ASSISTED LIVING FACILITIES WITH 5 BEDS OR LESS:
[\$100.00 (NALA Minimum)] + [\$10.50 (AHCA Assisted Living Facility Dues) x Total Number of Licensed Beds]



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Should your facility register for events, purchase products, or utilize any other service requiring payment during your membership term, the Nebraska Health Care Association will e-mail statements and invoices instead of mailing them. Please provide one or two e-mail addresses for the persons most responsible for paying your organization's bills. Keep a copy of this form for your records in order to keep your account updated with the most current employee e-mail addresses.

Please print or type clearly. Please return the form to MichaelaM@nehca.org.

Facility Name _____

Facility Address _____

City, State and Zip _____

Name of person taking care of our account _____

Telephone Number _____

Fax Number _____

E-mail (1) _____

E-mail (2) _____

There will be no collecting of e-mail address through harvesting or dictionary attacks. E-mail addresses may not be sold for the purpose of sending unsolicited bulk e-mail. The staff or other agents may not distribute unsolicited e-mail directly or indirectly on the NHCA network or with any of the NHCA-owned equipment.

If your facility is tax-exempt, complete Form 13, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, and fax or mail the completed Form 13 to: NHCA/NALA, 3900 NW 12th St Ste 100, Lincoln NE 68521-3037. You may download Form 13 from this Web site:

<http://www.revenue.ne.gov/tax/current/current.html> (select "Sales and Use Tax")