

**NEBRASKA HEALTH CARE ASSOCIATION
AND ITS AFFILIATE, NEBRASKA ASSISTED LIVING ASSOCIATION**

3900 Northwest 12th Street, Suite 100
Lincoln, Nebraska 68521-3037
Phone: 402-435-3551 Fax: 402-475-6289
www.nehca.org
Serving Those Who Serve

For NHCA/NALA Office Use: <input type="checkbox"/> EXCEL <input type="checkbox"/> AHCA <input type="checkbox"/> CYMA <input type="checkbox"/> ACCESS Acct ID: _____

APPLICATION FOR FACILITY MEMBERSHIP

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

→ *We use e-mail for delivery of selected information to members. Please keep us informed of your current e-mail address!*

Membership Application for: <input type="checkbox"/> Nebraska Health Care Association Long Term Care Licensed Beds Only (SNF, NF, ICF, ICF-MR, SWING) <input type="checkbox"/> Nebraska Assisted Living Association Assisted Living Licensed Beds Only <input type="checkbox"/> Both NHCA and NALA Licensed Beds in Long Term Care <u>and</u> Assisted Living	Number of Licensed Beds: (Dues are based on the number and type of licensed beds.) _____ Nursing Facility Beds (SNF, NF) _____ ICF-MR Beds _____ SWING Beds _____ Assisted Living Beds	Type of Operation: _____ Non-Profit Independent Owner _____ Non-Profit Multi-Facility Owner _____ Proprietary Independent Owner _____ Proprietary Multi-Facility Owner _____ Governmental (City, County, State, District) Legislative District: _____
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Name of Administrator _____ Residence Phone _____
 (Designated Representative for membership voting purposes) (optional)

 Name of Alternate Designated Representative _____
 (For voting purposes when Administrator is unable to vote)

 Name and Address of Owner _____
 Phone Number of Owner _____
 Name and Address of Management Corporation _____
 Phone Number 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, the appropriate District of the Nebraska Health Care Association and/or Nebraska Assisted Living Association, and the American Health Care Association. Membership dues shall be in accordance with the current dues schedule and paid in accordance with the accepted payment plan of the Nebraska Health Care Association, Inc. Membership is on a calendar year basis. Dues are pro-rated for new members applying after January of each year.

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. See the back side of this application form for information on termination of membership.

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. Dues payments may be deductible by members as ordinary and necessary business expenses subject to restrictions imposed as a result of association lobbying activities. NHCA estimates that the nondeductible portion of your 2010 dues—the portion which is allocable to lobbying—is 35.7048%.

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: _____
 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: OCTOBER 22, 2009

EFFECTIVE DATE: JANUARY 1, 2010

FACILITY MEMBERSHIP IS AN ANNUAL OBLIGATION AUTOMATICALLY RENEWED UNLESS TERMINATED IN WRITING BY DECEMBER 15, 2009, FOR 2010 MEMBERSHIP.

NHCA DUES ASSESSMENT:

NHCA Dues (SNF/NF/ICF-MR or HospSwing Beds)	AHCA Dues (SNF/NF/ICF-MR or HospSwing Beds)	Total Dues (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 2010. (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:

NALA Dues (Assisted Living Beds)	AHCA (NCAL) Dues (Assisted Living Beds)	Total Dues (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 2010. (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]



An Affiliate of the American Health Care Association

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The Nebraska Health Care Association Accounting Department has moved into the electronic age. We are e-mailing statements and invoices instead of mailing them. Our accounting system now allows two e-mail addresses per account. What we need from you is one or two e-mail addresses for where you want the invoices e-mailed. This should be the e-mail addresses for the persons most responsible for paying your bills. Please keep a copy of this form for your records in order to keep your account updated in case of employee changes. **Please print or type clearly. You may also return the form to jeaninev@nehca.org.**

The e-mail address we have on file will appear on invoices and statements. On the invoice copy, it will be on the lower portion of the invoice by your account information. On the statements, it will be on the upper portion by your account information.

Facility Name _____

Facility Address _____

City, State, and Zip Code _____

Name of person taking care of our account _____

Telephone Number _____

Fax Number _____

E-mail Address (1) _____

E-mail Address (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.





Nebraska Resale or Exempt Sale Certificate

FORM
13

for Sales Tax Exemption

• Read instructions on reverse side/see note below

NAME AND MAILING ADDRESS OF PURCHASER			NAME AND MAILING ADDRESS OF SELLER		
Name			Name		
Street or Other Mailing Address			Street or Other Mailing Address		
City	State	Zip Code	City	State	Zip Code

Check Type of Certificate

Single Purchase Blanket If blanket is checked, this certificate is valid until revoked in writing by the purchaser.

I hereby certify that the purchase, lease, or rental by the above purchaser is exempt from the Nebraska sales tax for the following reason:

Check One Purchase for Resale (Complete Section A) Exempt Purchase (Complete Section B) Contractor (Complete Section C)

SECTION A—Nebraska Resale Certificate

Description of Item or Service Purchased

I hereby certify that the purchase, lease, or rental of _____ from the above seller is exempt from the Nebraska sales tax as a purchase for resale, rental, or lease in the normal course of our business, either in the form or condition in which purchased, or as an ingredient or component part of other property to be resold.

I further certify that we are engaged in business as a: Wholesaler Retailer Manufacturer Lessor
of _____
Description of Product Sold, Leased, or Rented

If None, State Reason

and hold Nebraska Sales Tax Permit Number 01-

or Foreign State Sales Tax Number _____ State _____

SECTION B—Nebraska Exempt Sale Certificate

The basis for this exemption is exemption category _____ (Insert appropriate category as described on reverse of this form.)

If exemption category 2 or 5 is claimed, enter the following information:

Description of Item(s) Purchased	Intended Use of Item(s) Purchased
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If exemption categories 3 or 4 are claimed, enter the Nebraska Exemption Certificate number. 05-

If exemption category 6 is claimed, seller must enter the following information and sign this form below:

Description of Item(s) Sold	Date of Seller's Original Purchase	Was Tax Paid when Purchased by Seller? <input type="checkbox"/> YES <input type="checkbox"/> NO	Was Item Depreciable? <input type="checkbox"/> YES <input type="checkbox"/> NO
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SECTION C—For Contractors Only

1. Purchases of Building Materials or Fixtures:

As an Option 1 or Option 3 contractor, I hereby certify that purchases of building materials and fixtures from the above seller are exempt from Nebraska sales tax. My Nebraska Sales or Consumer's Use Tax Permit Number is: 01-

2. Purchases Made Under Purchasing Agent Appointment on behalf of _____:
(exempt entity)

Pursuant to an **attached** Purchasing Agent Appointment and Delegation of Authority for Sales and Use Tax, Form 17, I hereby certify that purchases of building materials, and fixtures are exempt from Nebraska sales tax.

Any purchaser, or their agent, or other person who completes this certificate for any purchase which is other than for resale, lease, or rental in the regular course of the purchaser's business, or is not otherwise exempted from the sales and use tax under Neb. Rev. Stat. §§77-2701 through 77-27,135, shall in addition to any tax, interest, or penalty otherwise imposed, be subject to a penalty of \$100 or ten times the tax, whichever amount is larger, for each instance of presentation and misuse. With regard to a blanket certificate, this penalty shall apply to each purchase made during the period the blanket certificate is in effect. Under penalties of law, I declare that I am authorized to sign this certificate, and to the best of my knowledge and belief, it is correct and complete.

sign
here ▶

Authorized Signature

Title

Date

NOTE: Sellers must keep this certificate as part of their records. DO NOT SEND TO THE NEBRASKA DEPARTMENT OF REVENUE.

Incomplete certificates cannot be accepted.

www.revenue.ne.gov, (800) 742-7474 (toll free in NE and IA), (402) 471-5729

**For instructions on Form 13, go to this Web page:
http://www.revenue.state.ne.us/tax/current/f_13.pdf**

6-134-1970 Rev. 3-2009
Supersedes 6-134-1970 Rev. 10-2007

Revised November 2009
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