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For NNFA/NALA Office Use:
 ACCTNG NHCADB
 AHCADB

FACILITY MEMBERSHIP APPLICATION

Name of Facility _____ Date _____
 Address _____ City _____ Zip _____
 Facility Phone (include area code) _____ Fax (include area code) _____
 Facility Website _____
 Name of Administrator (Designated Representative) _____
 Email _____ Cell Phone (include area code) _____
 (Cell phone numbers for emergency contact only. Cell phone numbers will not be published.)

Membership Application for:

- Nebraska Nursing Facility Association (NNFA)
Nursing Facility Licensed Beds Only
(SNF, NF)
- Nebraska Assisted Living Association (NALA)
Assisted Living Licensed Beds Only
- Both NNFA and NALA
Nursing Facility and Assisted Living
Licensed Beds

Number of Licensed Beds:

(Dues are based on the number
and type of licensed beds)
 _____ Nursing Facility Beds
(SNF, NF)
 _____ 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: _____

DUES PAYMENT PLAN

- _____ ANNUAL..... Dues are billed January 1. FACILITIES THAT PAY BY JANUARY 15 MAY DEDUCT 2.5%.*
- _____ SEMI-ANNUAL ... Dues are billed January 1 and July 1.*
- _____ QUARTERLY Dues are billed January 1, April 1, July 1, and October 1.*
- _____ MONTHLY Dues are billed on the 1st of each month.*

*DELINQUENCY POLICY: Payment terms are 30 days. A 1.5% per month finance charge will be imposed on the outstanding principal balance not paid by the due date.

MEMBERSHIP DUES

Dues include membership in the Nebraska Nursing Facility Association and/or Nebraska Assisted Living Association, the appropriate district of the Nebraska Nursing Facility Association and/or Nebraska Assisted Living Association, and the American Health Care Association (AHCA) and/or the National Center for Assisted Living (NCAL). 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. The dues policy is available at nehca.org/2021membership.

RESPONSIBILITIES

The undersigned hereby agrees to abide by the policies of the Nebraska Health Care Association. Member applicants are subject to approval by the Association's Board of Directors. Information on termination of membership is available at nehca.org/2021membership.

Signed _____ Title _____ Date _____

Contributions or gifts to the Nebraska Nursing Facility 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.

NNFA/NALA estimates that the nondeductible portion of your 2021 dues – the portion which is allocable to lobbying – is 17.24%.

**Email is used for delivery of information to members.
Please keep NNFA/NALA informed of current email
addresses!**

**CHECK THIS BOX if you DO NOT WANT EMAIL
ADDRESSES PUBLISHED online or in printed
NNFA/NALA membership directories.**



Owner/Management Company

Owner _____
Address _____
City, St, Zip _____
Phone _____

Management Company _____
Address _____
City, St, Zip _____
Phone _____

IF APPLICABLE, please identify the individuals who fill these roles in your facility:

Nursing Facility Staff

NNFA Alternate Designated Representative
(For voting purposes when the administrator is unable to vote)

Name: _____

Email: _____

Director of Nursing: _____

Director of Nursing Email: _____

Social Services Director: _____

Social Services Director Email: _____

Activities Director: _____

Activities Director Email: _____

Dietary Manager: _____

Dietary Manager Email: _____

Medical Director (Full Name): _____

Medical Director Email: _____

Assisted Living Facility Staff

NALA Alternate Designated Representative
(For voting purposes when the administrator is unable to vote)

Name: _____

Email: _____

Resident Services Director: _____

Resident Services Director Email: _____

Accounts Payable Contact

Invoices and statements are emailed. Please supply the information below for your accounts payable contact.

Name: _____

Phone: _____

Email (1): _____

Email (2): _____

If your facility is tax-exempt, send Form 13, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, by fax or mail to:

NNFA/NALA, 1200 Libra Dr Ste 100, Lincoln NE 68512-9628
Fax: 402-475-6289

Certifications

____ Nursing Facility Medicare Certification

____ Nursing Facility Medicaid Certification

____ Assisted Living Medicaid Certification

Checklist of Additional Services Provided by Your Facility

Place a check mark beside the additional services provided by your facility. (Definitions of services are available at nehca.org/2021membership.)

- ____ Bariatrics
- ____ Beauty/Barber
- ____ Care Management
- ____ Chore Services
- ____ Day Care Adult
- ____ Day Care Child
- ____ Home Health Care
- ____ Homemaker
- ____ Hospice
- ____ Independent Living
- ____ Meals Home-Delivered
- ____ Memory Support/Dementia Special Care Unit
- ____ Mental Health/Behavioral Health
- ____ Palliative Care
- ____ Pediatric
- ____ Personal Care Aides
- ____ Personal Emergency Response System
- ____ Podiatry
- ____ Rehabilitation
- ____ Respite
- ____ Telehealth
- ____ Traumatic Brain Injury
- ____ Ventilator Dependent
- ____ Veteran Administration Contracts
- ____ Wellness Clinic/Center
- ____ Other: _____