

Membership Application

FACILITY INFORMATION

Name of Facility: _____

Physical Address of Facility: _____

City/State/Zip: _____

Mailing Address (if different): _____

City/State/Zip: _____

Facility Phone: _____ Facility Fax: _____

Facility Website: _____ Administrator Email: _____

Administrator: _____ Cell: _____

TYPE OF FACILITY

Check all that apply

Proprietary Government Non-profit (other) Freestanding Hospital Based

NUMBER OF LICENSED LONG-TERM CARE BEDS

Insert number of DPHHS-licensed beds

_____ Nursing Facility _____ Assisted Living _____ CAH swing beds

MEMBERSHIP DUES

_____ Nursing Facility (\$62.00 per licensed bed) \$ _____

_____ Assisted Living Facility (\$31 per licensed bed) \$ _____

_____ Critical Access Hospitals (no nursing home beds) (\$750 per year) \$ _____

Make Check Payable and Mail to:

36 S. Last Chance Gulch, Suite A, Helena, MT 59601

Phone: 406-443-2876, ext. 2

For credit card payment, email this form and request to pay by card to rsimmons@rmsmanagement.com

Website: mthealthcare.org



MHCA ... PROVIDING LEADERSHIP AND EMPOWERMENT WITHIN THE LONG TERM CARE CONTINUUM THROUGH EDUCATION, ADVOCACY, INFORMATION AND SUPPORT TO OUR MEMBERS.