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 ($60.00 per licensed bed)	$_____
_____	Assisted Living Facility ($30 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

Montana Health Care Association

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