

APPLICATION FOR MEMBERSHIP

TO: Wisconsin Health Care Association, Inc.
121 East Wilson Street, Suite L200
Madison, WI 53703

Date: _____

Our facility is interested in membership in the Wisconsin Health Care Association, Inc.

Name of Facility _____ Licensed Bed Capacity _____

Address _____

City _____ State _____ Zip _____

Telephone No. _____ FAX No. _____

**E-Mail Address _____ Website _____

Licensure Level

- ____ 1. Skilled
- ____ 2. Intermediate
- ____ 3. Developmentally Disabled
- ____ 4. Personal
- ____ 5. CBRF - Class A
- ____ 6. CBRF - Class B
- ____ 7. CBRF - Class C
- ____ 8. Skilled - IMD
- ____ 9. Intermediate - IMD
- ____ 10. CBRF - IMD

Ownership

Non-Profit:

- ____ 1. Church-Affiliated
- ____ 2. Hospital-Affiliated

Proprietary:

- ____ 3. Chain
- ____ 4. Non-Chain

Government:

- ____ 5. County
- ____ 6. Non-County

Certification:

- ____ 7. Title 18 (Medicare)
- ____ 8. Title 19 (Medicaid)

(If chain-owned, name of chain: _____)

Name of Administrator _____

Name of Director of Nursing _____

Authorized Voting Representative _____
(if other than administrator)

Signature of Authorized Person _____

Membership Dues

WHCA: \$34.00 per licensed bed annually; plus \$75 annual Convention assessment, first quarter only.

** E-Mail is our main source of communication; please make sure you add an e-mail for the NHA to receive all important mailings.