

# NATIONAL ASSOCIATION OF LONG TERM HOSPITALS

## 2010 MEMBERSHIP APPLICATION

**HOSPITAL:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

MEDICARE PROVIDER NUMBER: \_\_\_\_\_

NUMBER OF LONG-TERM HOSPITAL BEDS: \_\_\_\_\_

CONTACT PERSON NAME &amp; TITLE: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**FACILITY-TYPE (check all that apply):**Free-Standing For-profit Satellite Not-for-profit Hospital-within-hospital Government-owned "Grandfathered" **MEMBER OF CHAIN ORGANIZATION** 

If yes, Name of parent/owner organization: \_\_\_\_\_

Number of other Long-Term Hospitals in this organization: \_\_\_\_\_

**DUES STRUCTURE:**

If chain organization, the "1st Member" must be the facility with highest number of long-term hospital beds. Please complete a Membership Application for each member of the organization.

<b>1st Member</b>		<b>Additional Members (Same Owner)</b>	
<b>BEDS</b>	<b>DUES</b>	<b>BEDS</b>	<b>DUES</b>
1-49	\$8,540	1-49	\$4,270
50-99	\$11,720	50-99	\$5,860
100-149	\$14,900	100-149	\$7,450
150-199	\$18,080	150-199	\$9,040
200+	\$19,670	200+	\$9,835

**PAYMENT:**

Please make check payable to:

National Association of Long-Term Hospitals  
342 North Main Street, Suite 301  
West Hartford, CT 06117-2507