

NATIONAL ASSOCIATION OF LONG TERM HOSPITALS

2011-12 MEMBERSHIP APPLICATION

HOSPITAL:

NAME: _____

ADDRESS: _____

MEDICARE PROVIDER NUMBER: _____

NUMBER OF LONG-TERM HOSPITAL BEDS: _____

CONTACT PERSON NAME & 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.

1st Member		Additional Members (Same Owner)	
BEDS	DUES	BEDS	DUES
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