## Nursing Facility Membership Application

**Facility Name:**

**Person Completing Form:**

**Facility Street Address:**

**City:**

**Zip:**

**Facility Telephone #:**

**Administrator Name:**

**Administrator Email:**

**Facility License #:**

**# Beds on Facility License:**

## Owner/Management Company Information

**Owner/Management Company Name:**

**Owner/Management Company Address:**

**City:**

**Zip:**

**Billing Contact Name:**

**Billing Contact Email:**

**Billing Contact Telephone #:**

**Regional Manager Name:**

**Regional Manager Email:**

# BILLING INFORMATION

## Skilled Nursing Facility Membership Dues Explained

Nevada Health Care Association:
**$ 6.57/licensed bed/month**

American Health Care Association:
**$ 1.72/licensed bed/month**

Political Action Committee:
**$ 1.88/licensed bed/month**

**TOTAL DUES PER BED PER MONTH: $ 10.17**

**Total Licensed Beds:**

**X $10.17 per bed**

**Total Dues Per Month:**

**Please Bill My Facility:**

**Start Billing Date:**

**Please Send Invoice To:**

**Please Email Invoice To:**

2990 Sunridge Heights Pkwy, Suite 140
Henderson, NV 89052