Arizona Health Care Association
Membership Application
Assisted Living Center

Community Name: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

Email: ______________________ Web-site: ______________________

State License(s) Supervisory: ______ Personal: __________Directed: ___________

Total number of units: ____________ Proprietary: _______ Non Proprietary: _________

Manager/ Administrator (Main point of contact):

Name: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

E-mail: ______________________

Signature of Manager or Representative: ______________________

Title: ______________________

Owners Name: ______________________________

Address:______________________________

City/State/Zip:______________________________

Phone: ______________________ Fax: ______________________

E-mail: ______________________

Membership Fee: $500.00 annually for community with 25 units or less ___________
25 units or more is $20.50 per unit per year:
Number of Units______ x $20.50 = $________

Payment Method: Check Enclosed Credit Card

For Credit Card Payments Only			
Type of Credit Card	Visa	Master Card	American Express
Credit Card #:			Expiration Date: /
Print Name as it appears on card:			
Signature:			

Mail this application to:
Arizona Health Care Association · 1440 E. Missouri Ave. Suite C-102
Phoenix, AZ 85014-2458 · Phone: 602-265-5331 · Fax: 602-265-4401

Revised 05/01/2008