

Vermont Health Care Association
PO Box 397, S. Barre, VT 05670
802-229-5700 (voice) sburnham@vhca.net

Nursing Home
Member Application and Information Sheet

Facility Name _____
Address _____

Telephone _____
Fax Number _____

Federal Medicare Provider Number: _____

VHCA Designated Voting Representative: _____

Owner/Affiliation _____
Address _____

Web Site _____

Tax status: for profit not for profit hospital based

Year established _____ Number currently on staff (all departments) _____

Nursing Facility Beds: _____ (level 1) _____ (level 2)

Residential Care Beds: _____ (level 3) _____ (level 4)

Medicare Certified Medicaid Certified ERC Waiver Beds
 JCAHO Accredited VA Approved

Department Heads

Administrator _____ email _____
Director of Nursing _____ email _____
Activity Director _____ email _____
Dietary Director _____ email _____
Social Services Dir. _____ email _____
Maintenance Director _____ email _____
Medical Director _____ email _____

Please accept this as our completed application for VHCA Membership.

Signature

Date

Mail or fax completed and signed application to:

**Vermont Health Care Association
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