

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

Assisted Living/Residential Care Home
Member Application and Information Sheet

Facility Name _____
Address _____

Telephone _____
Fax Number _____

VHCA Designated Voting Representative: _____
Owner/Affiliation _____
Address _____

Web Site: _____

Provider Type: Assisted Living Residential Care Home
Tax status: for profit not for profit hospital based

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

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

ERC Medicaid Waiver VA Approved ACCS Certified
 Accept SSI

Services provided (please check all that apply and list any additional services):
 Memory Care Hospice Program Palliative Care
 Wheelchair Equipped Van Security Alert System Respite Care
 Independent Living Short Term Rehab

Other services:

Department Heads

Manager _____ email _____
Head Nurse _____ email _____
Activity Director _____ email _____

Please list on the back of this form educational programs you would like to see offered.

Please accept this as our completed application for VHCA Membership.

Signature

Date

Mail or fax completed and signed application by to:

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