APPLICATION FOR MEMBERSHIP

Thank you for your interest in joining the Rhode Island Health Care Association. Please fill out this Application for Membership and send it, along with your Annual Fee payment, to the Association office.

This agreement is entered into as of the first day of _____, 2023 by and between_____(facility) and the Rhode Island Health Care Association.

Number of licensed beds:_____

In accordance with the Constitution and Bylaws of the Rhode Island Health Care Association, payment of an installment method is permitted, provided that an agreement to do so is entered into between the member and the Rhode Island Health Care Association.

The member agrees to pay the Rhode Island Health Care Association an Annual Fee of $225 (no discount allowed) in addition to $101.91 per bed annum (includes AHCA dues). The $225 Annual Fee is to be paid upon application for membership, and the first dues installment will be payable as of the month following approval by the Rhode Island Health Care Association's Board of Directors and General Membership.

CHOOSE ONE OF THE FOLLOWING METHODS OF PAYMENT

( ) MONTHLY Payment of dues is to be made no later than the last day of each month. (NO DISCOUNT MAY BE TAKEN)

( ) ANNUAL Payment is due within thirty (30) days of notification of member acceptance and no later than January 31 of each year on a renewal of current membership. (NO DISCOUNT MAY BE TAKEN)

A portion of all dues paid to the Rhode Island Health Care Association is paid on behalf of the member facility to the American Health Care Association for membership in the national organization.

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If a member fails to transmit dues on a timely basis and becomes in arrears for a ninety (90) day period, the member's status will be referred to the RIHCA Board of Directors for review.

*FACILITY:*_____*TELEPHONE:*_____

*ADMINISTRATIVE SIGNATURE:*_____

*FAX:*_____ *E-MAIL:*_____

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For RIHCA Use Only
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*Date Paid:*_____*Check Number:*_____*Amount:*_____

*Board Approval Date:*_____

*General Membership Approval Date:*_____

Please remit payment to:
Rhode Island Health Care Association
57 Kilvert Street, Suite 200
Warwick, RI 02886