

# OAHCP Facility Membership Application



## PLEASE COMPLETE ENTIRE APPLICATION

**Membership:** Membership of this Association shall be composed of institutions, establishments, entities or homes operating as Nursing Homes, ICF/IID, Adult Day Care, Residential Care facilities and which are licensed under the laws of the State of Oklahoma as such, which have been approved for membership by the Board of Directors.

1. A full member may be represented by any owner, officer or authorized representative of the member.
2. Full members or their designees shall have the right to attend Board of Directors and Business meetings of the Association and to serve on standing committees and task forces.
3. No entity may join this Association unless all entities affiliated by controlling ownership or management are also members. Disputes under this provision may be resolved by majority vote of the Board of Directors.
4. Full members must satisfy all dues, arrears, and assessments owed by them to the Association as designated by the Association Board of Directors.

### Facility Information:

Facility Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ County: \_\_\_\_\_  
Facility E-mail: \_\_\_\_\_ Web Site: \_\_\_\_\_  
Administrator: \_\_\_\_\_  
E-mail (Administrator): \_\_\_\_\_  
Facility Federal Medicare/Medicaid Provider Number: \_\_\_\_\_  
Preferred Billing Method: Corporate:  Facility:

### Corporate Ownership Information:

(Name of corporation operating facility/licensee)

Name: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Multi Facility Ownership

For Profit – Corporation	_____	For Profit Partnership	_____
For Profit Individual	_____	Non Profit Corporation	_____
Government – City	_____	Government – State	_____
Non-Profit – Hospital Affiliated	_____	Non-Profit – Church Affiliated	_____
Other:	_____		

### Number of Beds:

SNF/NF Beds: \_\_\_\_\_ SNF Beds: \_\_\_\_\_ NF Beds: \_\_\_\_\_  
ICF/IID: \_\_\_\_\_ Total Capacity: \_\_\_\_\_

All facilities under common ownership or operational control as defined in the OAHCP Constitution and By-Laws must make application for membership in the Association. Membership will continue until such membership is terminated in writing by either facility or OAHCP. The facility agrees to abide by the Constitution, Bylaws and the OAHCP Code of Ethics and may be terminated at any time, and through due process, for failure to meet standards and remittance of dues in a timely manner. By signing this application, applicant agrees to the terms and conditions set forth within.

\_\_\_\_\_  
Operator/Administrator Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## OAHCP Annual Dues

Annual Membership is from January – December

Dues for the Oklahoma Association of Health Care Providers are calculated on an annual basis based on the number of licensed beds. Membership into OAHCP includes mandatory membership into the American Health Care Association (AHCA) and their Assisted Living affiliate, the National Center for Assisted Living (NCAL).

### OAHCP Nursing Home and ICF/IID ANNUAL DUES STRUCTURE

**Please, check one of the following to indicate method of payment and return this page with your application for membership. Invoice reminders will be mailed in December and January.**

- Annual Dues Payment:  
**\$50.00 per licensed bed** **Due: January 20<sup>th</sup>**  
**[Example: 50 beds is  $50 \times \$50 = \$2,500$ ; paid by January 20<sup>th</sup> annually]**
- Semi-Annual Dues Payment: \$25.50 per licensed bed  
**\$51.00 Annually per licensed bed** **Due: Jan. 20<sup>th</sup> and July 20<sup>th</sup>**  
**[Example: 50 beds is  $50 \times \$51 = \$2,550 \div 2 = \$1,275$  twice a year]**
- Quarterly Dues Payment: \$13.25 per licensed bed per quarter  
**\$53.00 Annually per licensed bed** **Due: Jan. 20<sup>th</sup>, Apr. 20<sup>th</sup>, July 20<sup>th</sup>, Oct. 20<sup>th</sup>**  
**[Example: 50 beds is  $50 \times \$53 = \$2,650 \div 4 = \$662.50$  quarterly]**
- Monthly Dues Payment: \$4.59 per licensed bed per month  
**\$55.00 Annually per licensed bed** **Due: 20<sup>th</sup> of each calendar month**  
**[Example: 50 beds is  $50 \times \$55 = \$2,750 \div 12 = \$229.17$  monthly]**

**ICF/IID:** 6 Beds or less have a \$250.00 maximum per facility.

### Adult Day Care/Residential Care Annual Dues: \$500.00 Annually

**Note:** All dues can be paid on an annual or semi-annual basis

OAHCP dues are not deductible as a charitable contribution for tax purposes, but may continue to be deductible as a business expense. However, per Section 6033 (c) of the Internal Revenue Service Code for 1998, a reasonable estimate of 9% of OAHCP dues will be spent on lobbying and other expenditures subject to Section 162(e) (1) of the Code and therefore are not deductible for federal income tax purposes.

In compliance with Section 6033 (e) of the Internal Revenue Code (the Code), the American Health Care Association reasonably estimates that 25% of the 2016 AHCA dues will be spent on lobbying and other expenditures subject to Section 162(e)(1) of the IRC. Therefore, this portion of the dues is not deductible for Federal income tax purposes.



**Please check if you would like to join NAHCA; full annual payment of \$450.00 must be included with application. Make check payable to OAHCP.**

- I would like to join the National Association of Health Care Assistants