



**APPLICATION FOR INSTITUTIONAL MEMBERSHIP**

Application Date: \_\_\_\_\_ Desired Membership Effective Date: \_\_\_\_\_

The governing board of this organization hereby submits application for Institutional Membership in the South Dakota Association of Healthcare Organizations.

Name of Organization					Year Est.	
Address		City		State		Zip
Phone Number			FAX Number			
Name/Title of CEO						
Name of entity <b>managing / leasing</b> applicant organization (circle one if applicable)						
Address		City		State		Zip

1. a. Check type of organization:
- \_\_\_\_\_ Hospital
  - \_\_\_\_\_ Nursing Facility
  - \_\_\_\_\_ Home Health Agency
  - \_\_\_\_\_ Hospice Organization
  - \_\_\_\_\_ Assisted Living Center
- b. Check type of ownership/control of institution:
- \_\_\_\_\_ Church Related
  - \_\_\_\_\_ Nonprofit
  - \_\_\_\_\_ Other Nonprofit
  - \_\_\_\_\_ Investor Owned (For Profit)
  - \_\_\_\_\_ City
  - \_\_\_\_\_ County
  - \_\_\_\_\_ City-County
  - \_\_\_\_\_ State
  - \_\_\_\_\_ Federal

2. Total number of licensed beds:

Acute \_\_\_\_\_ Long Term \_\_\_\_\_ Assisted Living \_\_\_\_\_ Congregate Housing \_\_\_\_\_

3. Please list names and addresses of officers and members of governing board:

President	
Vice President	
Secretary	
Treasurer	
Other	

*I understand that a condition of Institutional Membership requires this facility to participate in the SDAHO data program(s) designed for this facility's license.*

Signed \_\_\_\_\_  
 Title \_\_\_\_\_

**FOR SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS USE ONLY**

Board Action:		Date:	
Dues Billed:		Paid:	