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**17 South High Street, Suite 1000**

**Columbus, Ohio 43215**

**614-228-9131**

**Application for Post-Acute Long-term Care Network Membership**

**Please complete and submit to Dawn Miller at** [**dawn.miller@shcare.net**](mailto:dawn.miller@shcare.net)

|  |  |  |  |
| --- | --- | --- | --- |
| Corporate Organization: |  | | |
| Corporate Address: |  | | |
| Tax ID Number: |  | | |
| NPI Number |  | | |
| Facility Names:  (Include SNF’s, AL’s, RCF’s, SLF’s, HHC, Hospice, etc.) |  | | |
| Corporate Contact Name: |  | | |
| Corporate Contact Email: |  | | |
| Corporate Contact Telephone Number: |  | | |
| CEO Name, Email, and Telephone Number: |  | | |
| Is the organization a member in good standing with LeadingAge Indiana? | | | Yes or No |
| Is the organization a not-for-profit? | | | Yes or No |
| Please list all services, facilities, and (certified beds/capacity for each) provided by your organization: | | | |
|  | | | |
| Please list the geographic areas your organization and facilities cover (counties and part of counties), with names and addresses: | | | |
|  | | | |
| Please Indicate your overall current Star Rating and Today’s Date for each facility: | | | |
|  | | | |
| **Mandatory Participation Criteria**: Please indicate your ability to participate in network contracting and quality requirements:   * Organization will participate in at least 80% of negotiated contracts. * Organization will comply with all IHSN quality program requirements. | | (circle)  Yes or No  Yes or No | |

Thank you for your application. The IHSN Board will consider your application. Completing of the application is not a guarantee of acceptance. If accepted, we will contact you ASAP with the appropriate corporate documents for completion.

Please contact Dawn Miller with any questions at [Dawn.Miller@shcare.net](mailto:Dawn.Miller@shcare.net)