AMERICAN CASE MANAGEMENT ASSOCIATION

ACMA MEMBERSHIP APPLICATION
(ALL INFORMATION SUBMITTED IN THIS APPLICATION IS CONFIDENTIAL)

☐**I am already a National member and I am joining a local chapter. My Membership number is:** _____
(For Chapter membership processing, please complete your membership number, Section A and Section E only)

I was recruited by: _____

SECTION A: CONTACT

First Name: _____ **MI:** _____ **Last Name**: _____

Birth date: _____ / _____ / _____ **Gender:** ____ ____
Month Day Year Female Male

Title: _____ **Credentials:** _____

Department: _____

Organization: _____

IMPORTANT: Please provide both home and work contact information. (Please type or print)

BUSINESS Mailing Address:			
City:		**Province/ County:**	
State:		**Zip:**	
Phone:		**Fax:**	
Country:			
Email:			

HOME Mailing Address:			
City:		**Province/ County:**	
State:		**Zip:**	
Phone:		**Fax:**	
Country			
Email:			

ACMA allows Members to customize their mailing preferences.
Please indicate at which of the above addresses you want to receive each ACMA correspondence.

	BUSINESS	**HOME**
Preferred Mailing Address: Membership card, conference brochuresand *Collaborative Case Management Journal*	☐	☐
Preferred E-Mail Address: Renewal notices, electronic reminders and event invitations	☐	☐

SECTION B: EDUCATION & LICENSE INFORMATION

UNDERGRADUATE INFORMATION

School: _____

Major: _____ **Date Completed:** _____

GRADUATE INFORMATION

School: _____

Major: _____ **Date Completed:** _____

License Number: **Nurse:** _____ **and/or SW:** _____

SECTION C: ASSOCIATIONPARTICIPATION

Please mark any areas of interest in which you desire to participate:

☐ Annual Meeting/Conference Planning
☐ Credentialing Issues
☐ Grant Writing
☐ Membership Service Development
☐ Membership Recruitment
☐ Professional Development/Mentorship
☐ Fundraising
☐ Publications
☐ Legislative Issues
☐ Other: _____

SECTION D: MEMBERSHIP LEVELS AND DESCRIPTIONS

Please check the option that best describes you in each section.

1.Profession:

__ Nurse __ Social Work __ Physician __Support Staff __ Other

2. Practicing Function:

Practicing Professional – Case Managers with a daily case load

Leadership - management or oversight of Case Management services

Clinical Documentation Specialist – professionals who provide Clinical Documentation Services for Hospital/Health Systems within case management services

Public Service Agent - Professionals providing or responsible for Case Management Services outside a Hospital/Healthcare System and work directly for a public service agency that does NOT provide any billable services

Physician Advisor - Physicians who work with a Hospital / Health Care system supporting the practice of Case Management

Other (please specify): _____

SECTION E: PAYMENT INFORMATION

You can enjoy many of the same membership benefits throughout the year at a convenient, local level. Add the Chapter's dues to your ACMA national dues and indicate on the Total Amount Enclosed line at right.

Chapters	Annual Dues
Arizona	No Annual Dues
Central TX	No Annual Dues
Connecticut	No Annual Dues
Dallas-Fort Worth	No Annual Dues
Eastern Pennsylvania	No Annual Dues
Florida	No Annual Dues
Georgia	No Annual Dues
Great Lakes	No Annual Dues
Greater Houston	$25.00
Illinois	No Annual Dues
Kentucky/Tennessee	No Annual Dues
Louisiana	No Annual Dues
Maryland	No Annual Dues
Massachusetts	No Annual Dues
Minnesota	No Annual Dues
Missouri/Kansas	No Annual Dues
Missouri/Illinois Gateway	$25.00
New Jersey	No Annual Dues
New York	No Annual Dues
North Carolina	No Annual Dues
Northern California	No Annual Dues
Ohio	No Annual Dues
Oregon	No Annual Dues
South Carolina	No Annual Dues
Southern California	No Annual Dues
Utah	No Annual Dues
Virginia	No Annual Dues
Washington	No Annual Dues
West Virginia	No Annual Dues
Western Pennsylvania	No Annual Dues
Wisconsin	No Annual Dues

National Membership Category (Check one)

☐ **Full ACMA member $135.00**

☐ **Retired, Student or Support Staff $60.00**

Chapter (Optional)

Write the chapter you wish to join _____

Chapter dues _____.

Fundraising (Optional)

Write in any amount you wish to donate to ACMA's Fundraising efforts: _____.

ACMA is a 501(c)3 non-profit organization and donations are tax deductible.

TOTAL AMOUNT ENCLOSED $_____.

Payment Method: ☐ Check/Money Order ☐ Credit Card

Card Number:_____

Expiration Date:_____ CVV/CSC:_____ Zip Code:_____

Name as it appears on card:_____

Signature:_____

Any returned checks will incur a $5.00 insufficient funds fee to be added to the dues amount.

Your ACMA membership will be valid for one full year from the end of the month it is processed in.

I attest that I meet the membership criteria as outlined above and the information on this application is accurate and current. By joining, each member of the American Case Management Association (ACMA) pledges and agrees to: Act honestly, truthfully, consistently and with integrity and free from outside influence in all professional and ACMA transactions and dealings; Be informed and adhere to the organization's missions, services, policies, and programs, and to inform others about the Association; Adhere to ACMA guidelines and policies; Not attempt to represent any acts or statements in such a way as to lead others to believe that they officially represent The ACMA, unless duly authorized by The ACMA Board of Directors; Nominate and vote for the best qualified personnel available after considering experience, membership and characteristics of individuals demonstrating potential to serve the Association

_____ _____

Applicant Signature **Date**

Please return this application to ACMA - fax to 501-227-4247 or mail to the address below. For questions, call ACMA at 501-907-2262.

ACMA • 11701 West 36th Street • Little Rock, AR 72211

Provided the application and payment are complete, please allow two weeks for processing.