APPLICATION FOR
CONGREGATE LIVING HEALTH FACILITY ACCREDITATION

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Name of Organization

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Address

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City State Zip

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Phone Fax Website

Name of CEO: ____________________________________ Email: ______________________________

Name / Title of Main Contact: ______________________________ Email: ______________________________

Accounts Payable Contact: ______________________________ Email: ______________________________

Number of Licensed Beds: _______________ Average Daily Census: ____________________

Services Provided: (please check all that apply)

- ☐ Medical Services
- ☐ Skilled Nursing Services (RN / LVN)
- ☐ Basic Respiratory Services
- ☐ Clinical Nutrition (Dietitian) Services
- ☐ Rehabilitation Services (PT, OT, SP)
- ☐ Mechanical Ventilation
- ☐ IV Medications
- ☐ Invasive Procedures
- ☐ Dialysis
- ☐ Wound Care
- ☐ Moderate Sedation
- ☐ Tube Feedings

Notes / Comments (please provide any additional information you would like CIHQ to be aware of)

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The undersigned understands and acknowledges that the information provided in this application is – to the best of his/her knowledge – accurate as of the date of application submission. The undersigned also acknowledges that he/she is authorized by his/her organization to submit this application

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Signature: Date

Name / Title: ____

Scan and email completed application to rcurtis@cihq.org or fax to 805-934-8588