



Empire State Association of Assisted Living Provider Membership Application

The Empire State Association of Assisted Living (ESAAL) offers the following membership categories:
Please check the appropriate membership category for your application.

Member Type (Select One)	Description	Annual Rate
<input type="checkbox"/> Provider Member	Currently DOH Licensed, Adult Home, Enriched Housing Program	\$28 per Adult Home or Enriched Housing Bed; \$33 per Assisted Living (ALP) Bed
<input type="checkbox"/> Associate Provider Member – Operational	Occupied Building in operation, with DOH license pending or in process of making application	\$28 per Bed
<input type="checkbox"/> Associate Provider Member – Non-Operational	New construction (not in operation) Adult Home, Enriched Housing Program and/or Assisted Living Residence with DOH license pending or in process of making application	\$15 per Adult Home or Enriched Housing Bed
<input type="checkbox"/> Affiliate Provider Member	Independent Senior Housing – DOH License not required	\$15 per Bed

Industry Partner Member All other categories, i.e. vendors for goods and services, academia, etc. (Please use the separate IP Membership application form for this membership category. Contact the Association at 518-371-2573 to have an IP application form faxed or emailed to you. The form is also available on ESAAL's website at www.esaal.org) \$650 Annually

Owner/Operator Information: (Name on License of the Individual, Business or Corporation Name)

Name: _____ Phone: _____
 Address: _____ Fax: _____
 City, State, Zip: _____ Web Site: _____

If business or corporation, please provide primary contact name:

Contact Person: _____ Phone: _____
 Address: _____ Fax: _____
 City, State Zip: _____ Email: _____

Number of years in the long-term care industry: _____

For all partnerships and corporations, please complete Page 3 of this form by listing the names of the organization's principals or board of directors.

(All applications for membership must be accepted by ESAAL's Board of Directors.)

Applicant must join all of its licensed adult home, enriched housing and assisted Living facilities.

Facility Information for 1st Location: Is this location the primary facility? Yes No

Facility Name: _____ Phone: _____

Facility Address: _____ Fax: _____

City, State, Zip: _____ County: _____

Name of Administrator: _____ Administrator's Email: _____

Web Site: _____ DOH Application Submitted & Pending

Number of Adult Home Beds: _____ Number of Assisted Living Program Beds: _____

Number of Enriched Housing Beds: _____ Total Number of Licensed Beds: _____

Year License Issued: _____ Are you currently operational Yes No
 With ACF License Without ACF License

Facility Information for 2nd Location:

Facility Name: _____ Phone: _____

Facility Address: _____ Fax: _____

City, State, Zip: _____ County: _____

Name of Administrator: _____ Administrator's Email: _____

Web Site: _____ DOH Application Submitted & Pending

Number of Adult Home Beds: _____ Number of Assisted Living Program Beds: _____

Number of Enriched Housing Beds: _____ Total Number of Licensed Beds: _____

Year License Issued: _____ Are you currently operational Yes No
 With ACF License Without ACF License

Facility Information for 3rd Location: (For additional facilities, attach information on separate page.)

Facility Name: _____ Phone: _____

Facility Address: _____ Fax: _____

City, State, Zip: _____ County: _____

Name of Administrator: _____ Administrator's Email: _____

Web Site: _____ DOH Application Submitted & Pending

Number of Adult Home Beds: _____ Number of Assisted Living Program Beds: _____

Number of Enriched Housing Beds: _____ Total Number of Licensed Beds: _____

Year License Issued: _____ Are you currently operational Yes No
 With ACF License Without ACF License

(All applications for membership must be accepted by ESAAL's Board of Directors.)

For partnerships, LLCs and corporations, please list the names of principals or the entity listed on the operation certificate(s).

Partnership/Corporation Name: _____

	Name	Email Address
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

Please select a payment option:

- Option 1: I elect to pay our Membership Dues annually.
- Option 2: I elect to pay our Membership Dues quarterly. Payments must be received by January 31, April 30, July 31 and October 31
- Option 3: I elect to pay our Membership Dues monthly. Payments must be received by the 30th of each month.

I understand that membership automatically renews annually unless the Association is advised in writing of resignation. Member facilities are responsible for all dues charged until such notification.

Authorized by (Signature: _____

Print Name: _____

Please make check payable to the Empire State Association of Assisted Living and return the completed application, check or credit card authorization, and copy of your facility's operating certificate(s) to:

Empire State Association of Assisted Living
646 Plank Rd., Suite 207
Clifton Park, NY 12065

Thank you for completing the Membership Application.

(All applications for membership must be accepted by ESAAL's Board of Directors.)