



2012 PROVIDER MEMBERSHIP APPLICATION

**ESAAL offers the following membership categories: Check the appropriate membership category for your application.
YOU MUST SEND IN A COPY OF YOUR OPERATING CERTIFICATE ISSUED BY NYS DOH WITH 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

APPLICANT MUST JOIN ALL OF ITS LICENSED ADULT HOME, ENRICHED HOUSING AND ASSISTED LIVING FACILITIES.

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

Name: _____ **Title:** _____ **Phone:** _____

Address: _____ **Fax:** _____

City: _____ **State:** _____ **Zip:** _____ **Web Site:** _____

If business or corporation, please provide primary contact name & title.

Name: _____ **Title:** _____ **Phone:** _____

Address: _____ **Fax:** _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

of yrs. in industry: _____

Company Type: LLC Corporation Partnership Sole Proprietorship

Business Type: For Profit Not-for-Profit 501 (c) (3) 501 (c) (6)

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.)

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
License Type: 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
License Type: 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
License Type: With ACF License Without ACF License

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 (Optional)
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.

Interest accrued at 1.5% each month on all over due balances after 30 days.

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: _____

If you have any Member Services questions please contact Carla Erhartic, at 518-371-2573 or email: cerhartic@esaal.org. Contact Andrea Cirabisi with any billing questions: acirabisi@esaal.org.

Return the completed application, copy of your facility's operating certificate(s) and payment method (either a check payable to the ESAAL or credit card authorization) to:

ESAAL
646 Plank Road, Suite 207
Clifton Park, NY 12065

PLEASE RETURN COMPLETED APPLICATIONS TO CARLA ERHARTIC at cerhartic@esaal.org

Thank you for completing the Membership Application



Credit Card Payment Authorization Form

Facility/Company Name: _____

Contact Person: _____

Phone No.: _____ Fax No: _____

Credit Card Information: (Please note: ESAAL only accepts the following credit cards.)

Credit Card: **(Please Check)** Visa Master Card Discover American Express

For Dues payment only: Annually Quarterly Monthly

Amount for Credit Card Charge: \$ _____

Required information for processing credit card:

Credit Card No: _____

CVV2 Code:

Expiration Date: _____ (The 3 or 4 digit code is located either on the front or back of the card.) _____

Name as listed on Card (Please Print): _____

Street Address of Authorized _____

Cardholder: _____

City, State, & Zip Code: _____

I hereby authorize ESAAL to charge my credit card the amount indicated on this form for the purpose stated. Without a signature your credit card will not be processed.

Cardholder's Signature: _____