



# Empire State Association of Assisted Living 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
<input type="checkbox"/> Industry Partner Member	All other categories, i.e. vendors for goods and services, academia, etc. <i>(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 <a href="http://www.esaal.org">www.esaal.org</a>)</i>	\$650 Annually

**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: \_\_\_\_\_

**Number of years in the long-term care 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.

**Please continue to the back of this form.**

(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 1<sup>st</sup> 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

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**Facility Information for 2<sup>nd</sup> 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

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**Facility Information for 3<sup>rd</sup> 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 (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 30<sup>th</sup> 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 questions, please contact Carla Erhartic, Member Services at 518-371-2573 or email: [cerhartic@esaal.org](mailto:cerhartic@esaal.org)

**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

**PLEASE RETURN COMPLETED APPLICATIONS TO Carla Erhartic @ [cerhartic@esaal.org](mailto:cerhartic@esaal.org)**

**Thank you for completing the Membership Application.**

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