



Empire State Association of Assisted Living

Care • Community • Connections • Every Day

PROVIDER MEMBERSHIP APPLICATION

ESAAL offers the following membership categories: Check the appropriate membership category for your application.
PLEASE ENCLOSE A COPY OF YOUR OPERATING CERTIFICATE ISSUED BY NYS DOH WITH APPLICATION

| Member Type (Select One) | Description | Annual Rate |
|---|---|---|
| <input type="checkbox"/> AH/EHP Provider Member - Operational | Currently DOH Licensed, Adult Home, Enriched Housing Program | \$28 per Adult Home or Enriched Housing Bed |
| <input type="checkbox"/> ALR/EALR/SNALR Provider Member - Operational | Assisted Living Residence, Enhanced ALR, Special Needs ALR | \$28 per ALR Bed |
| <input type="checkbox"/> Provider Member – Assisted Living Program (ALP) - Operational | Assisted Living Program Bed – (ALP) | \$33 per 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 ADULT HOME, ENRICHED HOUSING, ASSISTED LIVING
RESIDENCES AND ASSISTED LIVING PROGRAMS.**

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

Name: _____ Title: _____ Phone _____
 Address: _____ City _____ State _____ Zip _____
 Cell Phone _____ E-Mail _____
 # of years in Industry: _____

Primary Corporate Contact – If other than above

Name: _____ Title: _____ Phone _____
 Address: _____ City _____ State _____ Zip _____
 Cell Phone _____ Email _____
 # of years in Industry: _____

Company Type: LLC Corporation Partnership Sole Proprietorship
 Business Type: For Profit Not-for-Profit 501 (c) (3) 501 (c) (6)

(ALL APPLICATIONS FOR MEMBERSHIP MUST BE APPROVED BY ESAAL'S BOARD OF DIRECTORS.)

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.

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

Residence Name: _____ Phone: _____
Residence Address: _____ Fax: _____
City, State, Zip: _____ County: _____
Name of Administrator: _____ Administrator's email: _____
Cell Phone: _____ 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

Residence Information for 2nd Location:

Residence Name: _____ Phone: _____
Residence Address: _____ Fax: _____
City, State, Zip: _____ County: _____
Name of Administrator: _____ Administrator's email: _____
Cell Phone: _____ 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

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

Residence Name: _____ Phone: _____
Residence Address: _____ Fax: _____
City, State, Zip: _____ County: _____
Name of Administrator: _____ Administrator's email: _____
Cell Phone: _____ 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 |
|-------------------------------|-------|---------------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

Please select a payment option:

- Option 1: I elect to pay our Membership Investment Dues annually. (invoice will be sent)
- Option 2: I elect to pay our Membership Investment Dues quarterly. Payments must be received by January 31, April 30, July 31 and October 31(invoices will be sent)
- Option 3: I elect to pay my annual dues in full by Credit Card Payment. If you choose this option, complete the Authorization Form below.

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. Members are responsible for all dues charged until such notification.

Authorized by (Signature: _____)

Print Name: _____

If you have any Member Services questions, please contact Karen Thornton by phone (518)371-2573 or email at kthornton@esaal.org

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

By mail:
ESAAL
646 Plank Road, Suite 207
Clifton Park, NY 12065
By email:
kthornton@esaal.org



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Credit Card Payment Authorization Form

Residence/Company

Name: _____

Contact Person: _____

Phone No.: _____

Credit Card Information:

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

For Dues payment only: Annually Quarterly

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: _____