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
☐ **AH/EHP Provider Member - Operational**	Currently DOH Licensed, Adult Home, Enriched Housing Program	$28 per Adult Home or Enriched Housing Bed
☐ **ALR/EALR/SNALR Provider Member - Operational**	Assisted Living Residence, Enhanced ALR, Special Needs ALR	$28 per ALR Bed
☐ **Provider Member – Assisted Living Program (ALP) - Operational**	Assisted Living Program Bed – (ALP)	$33 per ALP Bed
☐ **Associate Provider Member -Operational**	Occupied Building in operation, with DOH license pending or in process of making application.	$28 per Bed
☐ **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
☐ **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: _____

Expiration Date: _____ **CVV2 Code:** **(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: _____