



## MEMBERSHIP FORM

Date Completed: \_\_\_\_\_  
Completed By: \_\_\_\_\_

Member ID#: \_\_\_\_\_

Join Date: \_\_\_\_\_

Check One:     New Member     Change of Information

### Facility/Property Information

Facility or Property Name: \_\_\_\_\_

Contact Person (Property): \_\_\_\_\_ Title: \_\_\_\_\_

Property Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Email: \_\_\_\_\_

Facility Email: \_\_\_\_\_ Facility Web Address: \_\_\_\_\_

### Sponsorship/Affiliation Information(if applicable)

Sponsor/Affiliation Name: \_\_\_\_\_

Sponsor Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Sponsor Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Email: \_\_\_\_\_

### Member Type (check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> CCRC  | <input type="checkbox"/> Senior Center     |
| <input type="checkbox"/> Nursing facilities (not part of a CCRC)       | <input type="checkbox"/> Adult day service |
| <input type="checkbox"/> Assisted living facility (not part of a CCRC) | <input type="checkbox"/> medical model     |
| <input type="checkbox"/> Senior housing site (not part of a CCRC)      | <input type="checkbox"/> social model      |

- Home health agency
- Home care agency
- PACE program
- Transportation program
- Meals on wheels
- Hospice program
- Geriatric clinic
- Other community service program

**Type of Sponsorship:**

- Religious
- Union
- Government
- Fraternal
- Hospital
- Community
- Private Foundation
- Other (specify)\_\_\_\_\_

**Tax Classification:**       501 (c) 3       501 (c) 4       501 (c) 6       For-Profit

Has the facility or community service organization ever been a member?       Yes     No

**Facility/Property Data (please state number of beds/units):**

- I) \_\_\_\_\_ Total Licensed Nursing Care Beds (include private pay & a, b, c below).
  - a) \_\_\_\_\_ Medicare Skilled Certified Beds
  - b) \_\_\_\_\_ Medicaid Licensed Beds
  - c) \_\_\_\_\_ Alzheimer Unit Residents
- II) \_\_\_\_\_ Assisted Living Units
- III) \_\_\_\_\_ Independent Living Units (Apartments; Cottages; Patio Homes)
  - a) \_\_\_\_\_ Federally Subsidized Senior Housing
  - b) \_\_\_\_\_ Tax Credit/Income Restricted Senior Housing
  - c) \_\_\_\_\_ Market Rate Senior Housing
  - d) \_\_\_\_\_ Other
- IV) \_\_\_\_\_ Adult Day Care (number of residents licensed/waiver slots approved)

If Federally assisted (e.g. 202), specify type of assistance:\_\_\_\_\_

Is the facility undergoing INITIAL construction?  Yes  No Indicate completion date\_\_\_\_\_

Is the facility in PLANNING stages?       Yes     No    Indicate planned construction date\_\_\_\_\_

On the last day of your reporting fiscal year, how many resident/clients were you serving? \_\_\_\_\_

On the last day of your reporting fiscal year, how many fulltime employees did you have?\_\_\_\_\_

How many individuals are currently on your active volunteer roster?\_\_\_\_\_



## MILLAGE INFORMATION FOR AAHSA

### Program Service Revenue

Program services are those activities your organization was created to conduct, plus programs and activities later added, that form the basis of your current federal tax exemption. Program service revenue includes, but is not limited to, revenue from nursing care, assisted living, independent living, adult day care services, home health care, transportation, outpatient services, hospice, meals and other community-based services.

Program service revenue would exclude your interest on savings and temporary cash investments, realized and unrealized gains or losses, special events and activities, charitable contributions, and any other services unrelated to AAHSA's mission.

The program service revenue should come from IRS Form 990 (Line #2) of the most recently completed fiscal year.

1. If your organization does not file **Form 990** with the IRS, provide program service revenue from one of the following documents using IRS definition (see above) for program service revenue.
  - The organization's audited financial statement
  - Medicaid Cost Report
  - Profit and loss statement

2. Please report your program service revenue and fiscal year it represents:

\_\_\_\_\_

Program Revenue

\_\_\_\_\_

Fiscal Year

3. Certification Status (check if applicable):  Medicaid  Medicare

### Supportive Services

So that AAHSA can better understand those services offered by our member organizations, please **check all services** that you have included in program service revenue above.

- |   |   |
|---|---|
| <input type="checkbox"/> Alzheimer's Care           | <input type="checkbox"/> Rehabilitation       |
| <input type="checkbox"/> Congregate Meals           | <input type="checkbox"/> Respiratory Care     |
| <input type="checkbox"/> Occupational Therapy       | <input type="checkbox"/> Respite Care         |
| <input type="checkbox"/> Pharmacy                   | <input type="checkbox"/> Sub Acute Care       |
| <input type="checkbox"/> Physical Therapy           | <input type="checkbox"/> Service Coordination |
| <input type="checkbox"/> Social/Activities Programs | <input type="checkbox"/> Personal Care        |