



Empire State Association of Assisted Living

Care • Community • Connections • Every Day

PROVIDER MEMBERSHIP APPLICATION

Last updated 2026

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, ALP and/or Assisted Living Residence with DOH license pending or in process of making application	\$15 per Adult Home or Enriched Housing Bed

APPLICANT MUST JOIN ALL OF ITS ADULT HOME, ENRICHED HOUSING, ASSISTED LIVING RESIDENCES AND ASSISTED LIVING PROGRAMS THAT OPERATE IN NEW YORK.

ESAAL Bylaws: If a member, or any entity in which a member or the principals of such member shall have an ownership interest of ten (10%) percent or more, is the licensed operator of, administrator of, or provides management or administrative services to a licensed NY adult care facility, then each of such above-referenced facilities must join and become members of ESAAL.

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: _____

Business Type: For Profit Not-for-Profit

(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.	_____	_____

Organization Name _____

Membership Start Date for Billing _____

(the start date will be the first of the month following the date approved for membership)

Membership is pro-rated on a calendar year basis.

Please select a payment option:

- Option 1: **I elect to pay our Membership Investment Dues Annually.** (members electing to pay annually will be billed a prorated amount on the start date documented above through December 31). (Annual Billing will occur on January 1 each subsequent year)
- Option 2: **I elect to pay our Membership Investment Dues Quarterly.** (members electing to pay quarterly will be billed a prorated amount on the start date documented above through the end of the current quarter) (Quarterly billing will occur on January 1, April 1, July 1 and October 1)

REGARDLESS OF WHICH PAYMENT OPTION YOU CHOOSE, ALL INVOICES MUST BE PAID WITHIN 30 DAYS

Please select the method to receive your invoices:

- By Mail:** Name of person to receive the invoice: _____
Address to send invoice: _____
- By EMAIL*:** Name of person to receive the invoice: _____
Email address: _____

*if you choose to receive invoices by email, you may pay directly online or send your payment by check.

You may also choose to pay now, using the credit card authorization below:

- I elect to pay my dues by Credit Card Payment. If you choose this option, complete the Authorization Form below. **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 membership 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 203
Clifton Park, NY 12065
By email: kthornton@esaal.org**



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: \$ _____

Recurring Charge Optional: By checking this box, I authorize ESAAL to automatically charge my card on a recurring basis for dues according to my specified schedule above.

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: _____