Empire State Association of Assisted Living

Care • Community • Connections • Every Day

PROVIDER MEMBERSHIP APPLICATION

Last updated January 2021

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, 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)

☐ Option 3: **I elect to pay our Membership Investment Dues Monthly.** (members electing to pay monthly will be billed on the first day of each month effective on the start date above.)

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 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** ☐ **Monthly**

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: _____

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: _____