

Assisted Living Association of Alabama

MEMBERSHIP APPLICATION

Member Name (ALF / Company) _____

Primary Representative/Contact Person _____

Title _____ Phone _____

Address _____ City _____

State _____ Zip _____ County _____

Fax (_____) _____ E-mail _____

ANNUAL MEMBERSHIP DUES

(Check the appropriate type of membership and provide the related information on the reverse side)

_____ **ACTIVE MEMBER (voting)**

\$21 per bed

State Licensed ALFs

All facilities under common ownership must be active members.

_____ **PROVISIONAL MEMBER (nonvoting)**

\$200

Facilities under development or construction – ALAA will prorate to active membership if licensed during the year.

_____ **INDIVIDUAL MEMBER (nonvoting)**

\$125

Individuals affiliated with a member facility or advocates and participants of services for the elderly population in the state.

****PROCEED TO SECOND PAGE****

_____ **ASSOCIATE MEMBER (nonvoting)**

\$500

Any corporation or business associated with selling products or services to the assisted living industry.

**** **PLEASE COMPLETE BOTH SIDES OF THIS APPLICATION** ****

The membership fee is for a fiscal year of membership, July through June. Initial membership dues will be prorated on a quarterly basis. Upon review and approval of your membership application by the ALAA Board of Directors, you will receive a membership certificate and be officially added to the ALAA directories.

Total Paid to ALAA \$ _____

YOU MAY PAY DUES BY CHECK OR CHARGE TO YOUR VISA, MASTERCARD, DISCOVER or AMEX:

****3% credit card processing fee will apply****

Card Type: MC [] Visa [] Discover [] AMEX []

Name on Card: _____ Card Number: _____ CW _____

Expiration Date: _____ Signature: _____

Mail to: Assisted Living Association of Alabama
Post Office Box 288, Helena, Alabama 35080

Phone (334) 262-5523

Fax (334) 262-4603

UPDATED 7/22

ACTIVE MEMBER APPLICANTS, please complete:

Administrator _____

Number of Licensed Beds _____

Have Specialty Care Unit: YES NO If yes, how many specialty care beds? _____

Respite Care Available: YES NO

ALF is Owned by: Individual Name _____

Address _____

City/State/Zip _____

Corporation Name _____

Contact Person /Title _____

Address _____

City/State/Zip _____

Phone: _____ Fax: _____

Have ALFs in what other states: _____

Medical Director's Name _____

RN or Director of Nursing's Name _____

Pharmacy Consultant's Name _____ Pharmacy's Name: _____

PROVISIONAL MEMBER APPLICANTS, please complete:

Number of beds planned for facility: _____ Type of Facility: Traditional Specialty Care

Facility will be owned by: Individual Partnership Corporation

Projected Date of Opening: _____

ASSOCIATE MEMBER APPLICANTS, please complete:

Corporate contact for exhibits, meetings, information, etc. _____

INDIVIDUAL MEMBER APPLICANTS, please complete:

Are you affiliated with ANY Assisted Living Facility? Yes () No ()

If Yes, Name of Facility: _____

Are you employed by ANY business /Associate Member that sells products or provides services to ANY Assisted Living Facility? Yes () No () If Yes, Name of Business: _____

Signature _____

Printed Name _____

Your Active Membership into ALAA will provide you:

- Industry Profile Information**
- A Statewide Advocate for ALF Providers**
- Participation in Setting a Legislative Agenda**
- Regional, State, and National Educational & Training Seminars**
- Group purchasing Opportunities and Savings**
- Discounts on state-of-the-art Educational and Training Materials**