



2009 Membership Application for Non-Profit Providers

Name of Facility/Community/Service Provider _____

Address _____ City _____ State _____

Zip _____ County _____ Telephone _____ Fax _____

Web Site _____ E-Mail _____

US Cong. District#: _____ MD Leg. District _____ (Call MD Bd. of Elections: 800-222-VOTE) District of Columbia: _____

CEO and/or Administrator (Main point of contact)

Name _____ Title _____

Address if (different:) _____

Phone (if different:) _____ Fax (if different:) _____ Email (if different:) _____

Billing Contact (if different from main contact above)

Name _____ Title _____

Address if (different:) _____

Phone (if different:) _____ Fax (if different:) _____ Email (if different:) _____

Is billing contact part of a multiple campus facility/corporation? Y ___ N ___ Name of Corp _____

Facility Composition

Total employees _____ FT _____ PT

Level of Care Offered: _____ Assisted Living _____ Community Based Service
_____ Continuing Care Retirement Community _____ Hospital Based Nursing Center _____ Multi-Level Provider
_____ Independent/Subsidized Housing _____ Nursing/Rehab Center

Nursing Care: (enter #) _____ Total Nursing Beds
Bed Types: _____ Alzheimer _____ Extended _____ Subacute _____ Medicaid _____ Medicare
Service Types: (Check if applicable): _____ Hospice Care _____ Respite Care _____ Accepts Medicaid
_____ Accepts Medicare

Assisted Living: (enter #) _____ Total Assisted Living Beds
Level of Care: (Check if applicable) _____ Level 1 lowest _____ Level 2 medium _____ Level 3 highest

Adult Day Care Daily (ADC): (enter #) _____ Total Licensed Capacity
Type of Service: _____ Adult Day Care _____ Hospice _____ Home Health _____ Respite Care
_____ Residential Services (skilled care—IV therapy...)
Other (please specify type):

Under Construction: Is the facility undergoing development or construction? Y _____ N _____
Begin Date _____ End Date (estimated) _____

Membership Recommended to me by: _____ (name and /or organization)

>>>> *Turn Page For Dues Calculation*>>>>

Non-Profit Providers 2009 Dues Calculation

LifeSpan

Nursing & Multi-level Care Campuses

Nursing Care: \$28/unit x _____ No. of Units = \$ _____
 Assted Living: \$28/unit x _____ No. of Units = \$ _____
 Indep. Housing: \$20/unit x _____ No. of Units = \$ _____

Free Standing AL, CBS:

Assisted Living: \$21/unit x _____ No. of Units = \$ _____
 Community-Based Services: \$375 \$ _____
 Under Construction \$375 \$ _____

*LifeSpan minimum/maximum: \$375/\$18,073

LifeSpan Total \$ _____

AAHSA

(AAHSA Under Construction Flat rate: \$350.00)

millage rate plus base rate

Prg svc rev of 0-\$999,999 x .0004 + \$0
 Prg svc rev of \$1 mill-\$9,999,999 x .00035 + \$50
 Prg svc rev \$10 mill(+) x .00030 + \$550

Determine your organization's FY08

program service revenue: \$ _____

x millage rate \$ _____

+ base rate \$ _____

AAHSA Total \$ _____

+ ***MANPHA fee** \$ 5.00

*The \$5.00 fee goes to MANPHA, the non-profit arm of LifeSpan Network.

Pay this amount for your 2009 dues: \$ _____

MAIL COMPLETED APPLICATION AND DOCUMENTATION TO:

**Joan Hyman, Director of Member Services
 LifeSpan Network, 10280 Old Columbia Road, Suite 220, Columbia, MD 21046**

Your application will be referred to the Board of Trustees for consideration. Incomplete applications will be returned. Dues will be invoiced after approval of membership by the Board of Trustees. Dues include membership in AAHSA but not ALFA. Interested in joining ALFA? Contact ALFA at 703-691-8100 or www.alfa.org.

Dues payments to LifeSpan are not deductible as charitable contributions for federal income tax purposes. Dues payments are deductible by members as an ordinary and necessary business expense.

Criteria For Membership

1. The member is committed to the development of community linkages and services, both for the well being of the person served as well as that of the larger community, and should assure continuity of care either within a facility or elsewhere through conscientious planning.
2. The member facility shall have a nondiscriminatory policy indicating that no person shall be excluded from participation in, be denied of, or be subjected to discrimination in its program for services.
3. The member is licensed according to the types of care it purports to provide within the context of local requirements.

Compliance

1. Each member will certify that it is in compliance with the standards of membership at the time of renewal of its annual dues.
2. Compliance will be assumed until a complaint has been filed.
3. The policy and procedures of compliance as outlined will be posted only by exception.

I certify that we are in compliance with LifeSpan Network membership criteria. I am enclosing a copy of our current license to provide services indicated above (if applicable).

 Chief Executive Officer's/Administrator's Signature

 Date

