

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)
(nonvoting)

\$17 per bed

State Licensed ALFs

All facilities under common ownership must be active members.

_____ PROVISIONAL MEMBER

\$100

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

_____ INDIVIDUAL MEMBER (nonvoting)
(nonvoting)

\$25

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

_____ ASSOCIATE MEMBER

\$450.00

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 BY CHECK OR CHARGE DUES TO YOUR VISA OR MASTERCARD:

Card Type: MC [] Visa []

Name on Card: _____ Card

Number: _____

Expiration Date: _____

Signature: _____

Mail to: Assisted Living Association of Alabama
5921 Carmichael Road ♦ Montgomery, AL 36117

Phone (334) 262-5523

(800) 826-9410

Fax (334) 262-4603

ACTIVE MEMBER APPLICANTS, please complete:

Administrator _____

Number of Licensed Beds _____

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

Adult Day Care Available: YES NO 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 _____

Nurse Consultant's Name _____

Pharmacy Consultant'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. _____

Your Active Membership into ALAA will provide you:

Access to Free or Low Cost Compliance Consulting
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

State and National Legislative Directories

ALAA Communicator

Discounts on state-of-the-art Educational and Training Materials