



2009 Membership Application for Proprietary Providers

Name of Facility/Community/Service Provider
Address
City
State
Zip
County
Telephone
Fax
Web Site
E-Mail
US Cong. District#:
MD Leg. District:
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>>>>

Proprietary Providers 2009 Dues Calculation

Nursing & Multi-level Care Campuses:

Nursing Care:	\$42/unit X _____ No. of Units =	\$ _____
Assisted Living:	\$28/unit X _____ No. of Units =	\$ _____
Independent Housing (not HUD):	\$20/unit X _____ No. of Units =	\$ _____

Free Standing AL, HUD Housing, CBS:

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

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

TOTAL AMOUNT DUE \$ _____

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 will not include membership in AAHSA or 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 _____

