

Membership Application

Application Type:

- New Membership
- Change of Ownership: Effective Date: _____

Facility Type:

- Skilled Nursing Facility
- Assisted Living Level I
- Assisted Living Level II
- Residential Care Facility
- ICF/MR

Facility:

Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Administrator: _____ Email: _____

Telephone: _____ Fax: _____

Total # of Licensed Beds: _____ Facility License #: _____

Previous Name of Facility: _____

Ownership:

Owner Name/Company: _____ Email: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

Administrative Service Provider:

Company Name: _____

Contact Person: _____ Email: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

Signature of Applicant

Date

