110 Barnes Road Wallingford, CT 06492
Telephone (203) 678-4477 Facsimile (203) 678-4650
email: leadingagect@leadingagect.org website: www.leadingagect.org

2519 Connecticut Avenue, NW
Washington, DC 20008-1520
Tel: (202) 783-2242 Fax: (202) 783-2255
email: info@leadingage.org website: www.leadingage.org

Membership Application

Thank you for your interest in LeadingAge Connecticut membership. In order to process your membership application, please complete the following application. Please note that membership in LeadingAge Connecticut requires enrollment of all appropriate parts of an organization. An organization is defined as all corporate entities or part thereof controlled by a single chief staff executive or a common or significantly overlapping board of directors.

If you have any questions please contact us at (203) 678-4477.

Name of Principle Provider Organization: _____

Address: _____

Telephone Number: _____ Fax: _____

Website Address: _____

Public e-mail address: _____

President/CEO *(please insert proper title)*: _____

E-mail: _____

Administrator: _____

E-mail: _____

Sponsorship: _____

Sponsorship Type: ☐ Religious ☐ Community ☐ Fraternal ☐ Municipal

Other: _____

License:

Please attach a copy of your current facility license(s) and 501(C3) Certificates, if applicable.

Member Type *(check all that apply, fill in number if required)*:

☐ Life Plan Community
☐ Nursing facilities (not part of Life Plan Community)
☐ Assisted Living facility (not part of Life Plan Community)
☐ Senior housing site (not part of Life Plan Community)

☐ RCH
☐ Housing Unit
☐ Adult day services

☐ Home Care Agency
☐ Management Company

☐ Other community service programs

Please provide us with the following information for all of your related entities.

Chronic Disease Hospital beds
(If contact information is different from above list)
Name of Facility: _____
Contact Person: _____
Address: _____
Number of beds: _____

Skilled Nursing/Intermediate Care facility beds:
(If contact information is different from above list)
Name of Facility: _____
Contact Person: _____
Address: _____
Number of beds by type: _____

Residential Care Home beds
(If contact information is different from above list)
Name of Facility: _____
Contact Person: _____
Address: _____
Number of beds: _____

Assisted Living Units
(If contact information is different from above list)
Name of Facility: _____
Contact Person: _____
Address: _____
Number of units: _____

Housing Units *(Please classify type below)*

- ☐ Market-rate Senior Housing
- ☐ State-Funded Senior Housing
- ☐ Federally-Funded Senior Housing
  Specify: _____
- ☐ Tax Credit/Income Restricted Senior Housing (LIHTC)

  Number of units: _____

(If contact information is different from above list)
Name of Facility: _____
Contact Person: _____
Address: _____

LeadingAge Connecticut/LeadingAge National Dues Explanation
Program Service Revenue

Both LeadingAge Connecticut and LeadingAge National dues are calculated using dues band systems based on a member organization's program service revenue. In preparation for the billing, please provide us with the following information:

Program services are those activities your organization was created to conduct, plus programs and activities later added, that form the basis of your current federal tax exemption. Program service revenue includes, but is not limited to, revenue from nursing care, assisted living, independent living, adult day care services, home health care, transportation, outpatient services, hospice, meals and other community-based services.

Program service revenue would exclude your interest on savings and temporary cash investments, realized and unrealized gains or losses, special events and activities, charitable contributions, and any other services unrelated to LeadingAge's mission.

The program service revenue should come from IRS Form 990, Part 1, line 9 of the most recently completed fiscal year.

1. If your organization does not file **Form 990** with the IRS, provide program service revenue from one of the following documents using the IRS definition (see above) for program service revenue:
   - The organization's audited financial statement
   - Medicaid Cost Report
   - Profit and loss statement
   -

Affordable Housing Members – Please provide annual rental income if Program Service Revenue does not apply.

2. Please report your program service revenue and fiscal year it represents:

_____ _____
Program Revenue Fiscal Year

Support Services
So that we better understand those services offered by our member organizations, please check all services that you have included in program service revenue.

- ☐ Alzheimer's Care
- ☐ Congregate Meals
- ☐ Geriatric clinic
- ☐ Hospice Program
- ☐ Meals on Wheels
- ☐ Occupational Therapy
- ☐ PACE program
- ☐ Personal Care
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Rehabilitation
- ☐ Respiratory Care
- ☐ Respite Care
- ☐ Senior Center
- ☐ Service Coordination
- ☐ Social/Activities program
- ☐ Sub Acute Care
- ☐ Transportation program

Facility Information:

1. On the last day of your reporting fiscal year, how many residents/clients were you serving?_____
2. On the last day of your reporting fiscal year, how many fulltime employees did you have?_____
3. How many individuals are currently on your active volunteer roster?_____

Data Submitted by:

_____ _____
Signature Title