



2009 New Member Application Form

Section 1: General Information - Please print clearly.

Person Completing Form: _____ Phone: _____

Member Name: _____ Organization E-mail: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Organization Website Address: _____

1. Do you have a union or organized labor contract? Yes ___ Which one? _____ No ___
2. On the last day of your fiscal year, how many residents/clients were you serving? _____
3. On the last day of your reporting fiscal year, how many employees did you have? _____
4. How many individuals are currently on your active volunteer roster? _____

Section 2: Ownership/Affiliations

Home Office/Parent/Corporate Affiliation: _____

Address: _____ Phone: _____

Contact Person: _____

Is it: Religious: ___ Community: ___ Private: ___ Fraternal: _ Hospital: _ Government: _ Union: ___

Do you have affiliated or connected organizations either on your campus or in the greater community? Yes ___ No ___ If yes, please list (attach a list or use back of page if necessary):

Organization Name	City-State-Zip (Yes or No)	Included with your AOPHA Membership?

Section 3: Member Type and Services Provided - Check all that apply.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> CCRC | <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Senior Center | <input type="checkbox"/> Meals on Wheels |
| <input type="checkbox"/> Nursing Facility
(non-CCRC) | <input type="checkbox"/> Home Care Agency | <input type="checkbox"/> Adult Day Services | <input type="checkbox"/> Hospice Program |
| <input type="checkbox"/> Assisted Living
(non-CCRC) | <input type="checkbox"/> PACE Program | <input type="checkbox"/> Medical Model | <input type="checkbox"/> Geriatric Clinic |
| <input type="checkbox"/> Sr Housing Site
(non-CCRC) | <input type="checkbox"/> Transportation Program | <input type="checkbox"/> Social Model | <input type="checkbox"/> Other HCBS |

<u>Nursing Beds</u>	<u>Scope of Services</u>																																																																																																																																																						
Total Licensed #: _____ # of Dually Certified: _____ # of Medicare: _____ # of Medicaid: _____ # of Private Pay Only: _____ # of Hospital SNF: _____ County Bed #: _____	The services listed below may be provided at a nursing home (NH), resident care facility (RCF- also known as <i>assisted living</i>), independent living housing site (IL) or by a home and community based services provider (HCBS). Please indicate each service that is offered to residents, clients or tenants of this specific AOPHA membership, whether it is provided by your staff or under contract with another company or organization.																																																																																																																																																						
<p style="text-align: center;"><u>Licensed Residential Care Beds</u> (Assisted Living)</p> Total #: _____	<table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">NH</th> <th style="text-align: center;">RCF</th> <th style="text-align: center;">IL</th> <th style="text-align: center;">HCBS</th> </tr> </thead> <tbody> <tr><td>Adult Day Services:</td><td></td><td></td><td></td><td></td></tr> <tr><td> Medical Model:</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td> Social Model:</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>AIDS Care:</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td 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Services:</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Speech Therapy:</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Subacute Care:</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Transportation Program:</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Ventilation:</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> 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Therapy:	_____	_____	_____	_____	Secure Dementia Unit:	_____	_____	_____	_____	Senior Center:	_____	_____	_____	_____	Social/Activities Programs:	_____	_____	_____	_____	Specialized Blind Services:	_____	_____	_____	_____	Specialized Deaf Services:	_____	_____	_____	_____	Speech Therapy:	_____	_____	_____	_____	Subacute Care:	_____	_____	_____	_____	Transportation Program:	_____	_____	_____	_____	Ventilation:	_____	_____	_____	_____	Wellness/Geriatric Clinic:	_____	_____	_____	_____
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<p style="text-align: center;"><u>Independent Living Housing Units</u></p> Total #: _____ # of Market Rate: _____ # of Federally Assisted: _____ # of Tax Credit: _____ # of Other _____																																																																																																																																																							
Do you have a Service Coordinator? Yes _____ No _____																																																																																																																																																							

Section 4: 2009 Provider Member Dues Calculation - Please print clearly.

- AOPHA membership operates on a calendar year basis.
- All new members will receive a first year 50 percent discount.
- New provider member dues are prorated monthly for the first year of membership.
- Minimum dues base: \$700 annual dues minimum (AOPHA \$350/AAHSA \$350).
- Maximum dues on the AAHSA portion are \$8000. The AOPHA maximum is \$24,000.
- Dues are based on your organizational program service revenue:

Under \$1,000,000	x .0012	(AOPHA .00076) + (AAHSA .0004)
\$1,000,000- \$10,000,000	x .0011 + \$100	(AOPHA .00071+\$50) + (AAHSA .00035+\$50)
Over \$10,000,000	x .001 + \$1100	(AOPHA .00066+\$550) + (AAHSA.0003+\$550)

Based on the IRS definition, program services are activities your organization was created to conduct, plus programs and activities later added, forming the basis of your current federal tax exemption. Program service revenue includes, but is not limited to, revenue from nursing care, licensed residential care, 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 assets, special events and activities, charitable contributions, and any other services unrelated to AOPHA's mission. The programs service revenue should come from IRS Form 990 (Line #2) of the most recently completed fiscal year. If your organization does not file Form 990 with the IRS, provide program service revenue from one of the following documents using the above definition for program service revenue: Audited Financial Statement, Medicaid Cost Report, Profit and Loss Statement.

To calculate, use the table above to insert as appropriate for your organizational revenue:

A. _____	x	_____ %	+ \$ _____	= \$ _____	
Annual program revenue			Add flat fee if applicable	Annual dues amount or minimum of \$700	
B. _____		Divide by 2		= \$ _____	
Insert annual dues From line A				First year 50% discounted annual dues	
C. _____		Divide By 12		= \$ _____	
Insert discounted annual Dues from line B				Monthly prorated dues	
D. _____	x	_____		= \$ _____	
Insert prorated dues from line C		# of months remaining (begin with month after submission)		Total annual 2007 dues	

Please remit payment with this form by check or credit card to:
AOPHA, Attn: Membership Services, 855 South Wall Street, Columbus, Ohio 43206-1921

*** A 3% surcharge will be added if paying by credit card.**

For Credit Card ONLY: ___ Visa ___ Mastercard ___ American Express ___ Discover
Card Number: _____ Expiration Date: _____
3-Digit Number on Back of Card: _____
Name on Card: _____ Total: _____
Cardholder Signature: _____

Section 5: Communications - Please provide contact information for your staff.

To post your logo or picture on our Website, please send it to: mpyles@aopha.org in a jpeg format. Most AOPHA communications are distributed electronically.

01 President/CEO	_____			
	First Name	Last Name	Title	E-mail
02 Executive Director	_____			
	First Name	Last Name	Title	E-mail
03 Administrator	_____			
	First Name	Last Name	Title	E-mail
04 Asst. Administrator	_____			
	First Name	Last Name	Title	E-mail
05 Housing Director	_____			
	First Name	Last Name	Title	E-mail
06 Chief Operating Officer	_____			
	First Name	Last Name	Title	E-mail
07 Finance/Business Office	_____			
	First Name	Last Name	Title	E-mail
08 Marketing Director	_____			
	First Name	Last Name	Title	E-mail
09 Compliance Official	_____			
	First Name	Last Name	Title	E-mail
10 Comm. Services Director	_____			
	First Name	Last Name	Title	E-mail
11 Purchasing	_____			
	First Name	Last Name	Title	E-mail
12 Human Resources	_____			
	First Name	Last Name	Title	E-mail
13 Staff Development	_____			
	First Name	Last Name	Title	E-mail
14 Admissions	_____			
	First Name	Last Name	Title	E-mail
15 Activities Director	_____			
	First Name	Last Name	Title	E-mail
16 Director of Nursing	_____			
	First Name	Last Name	Title	E-mail
17 IT	_____			
	First Name	Last Name	Title	E-mail
18 Fundraising Director	_____			
	First Name	Last Name	Title	E-mail
19 Plant Operations	_____			
	First Name	Last Name	Title	E-mail
20 Assisted Living Director	_____			
	First Name	Last Name	Title	E-mail
21 Food Services	_____			
	First Name	Last Name	Title	E-mail
22 Social Services	_____			
	First Name	Last Name	Title	E-mail
23 Public Relations	_____			
	First Name	Last Name	Title	E-mail
24 MDS Coordinator	_____			
	First Name	Last Name	Title	E-mail
25 Other (Specify)	_____			
	First Name	Last Name	Title	E-mail