LeadingAge Illinois Application for Membership – For Profit

MEMBER INFORMATION

Provider or Organization Name____

Address____

City____________________ County ____________________ State _________ Zip Code __________________

Telephone____________________ FAX____________________ Website____________________

Medicare ID ____________________ EIN: ____________________

How did you hear about LeadingAge Illinois? ____

What are your primary interests in LeadingAge Illinois membership? ____

Primary Contact____

Primary Contact Title & Email ____

Names, titles and emails of other key personnel (e.g., CFO, COO, Director of Nursing, etc.):

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Number of employees: Full Time_______________ Part Time _______________ Total _______________

Number of residents served: _______________ Number of Clients Served: _______________

Planning stages or under construction? ❑ Expected opening date________________________

MANAGEMENT

❑ Self-managed

❑ Management company name______________________________ ❑For-profit ❑ Not-for-profit

Tax Exempt Status: ❑ 501 (c)(3) ❑ 501 (c)(4) ❑ Other *(please specify)*____________________________

SPONSORSHIP

Full Name of Parent Company or Sponsor: ____

(Parent organizations are those that have more than one community as part of their overall operation)

Primary Contact at Parent Company or Sponsor: ____

Email: ____ Address: ____

SERVICE TYPES – check all that apply at this community

❑ Assisted Living No. of Units ______

❑ CCRC No. of Skilled Nursing Beds____ No. of Assisted Living Beds____ No. of Housing Units____

❑ Skilled Nursing No. of Beds______ ❑ Medicare certified ❑ Medicaid certified

❑ HCBS

❑ Senior Housing

❑ Supportive Living

❑ Hospice

Additional Information – check all that apply at this community

❑ Intermediate Care No. of Beds ______

❑ Sheltered Care No. Licensed______ No. Occupied______

❑ ICF

❑ Independent Living

HOUSING

❑ Market Rate Housing No. of Units______ ❑ Public Housing Authority No. of Units______

❑ Tax Credit-Funded Housing No. of Units______ ❑ HUD Subsidized Housing No. of Units______

HUD Program Type: Section: ❑ 221d3 ❑ 202(old) ❑ 202 ❑ 231 ❑ 232 ❑ 236 ❑ PRAC

❑ Other Housing Type (Please specify):____No. of Units______

Home and Community Based Services (HCBS)

If HCBS, specify type(s) of services (check all that apply):

- ❑ Adult Day Services
- ❑ Memory Care
- ❑ Blind/Visually Impaird Services
- ❑ Congregate Meals
- ❑ Durable Medical Equipment
- ❑ Geriatric Clinic
- ❑ HCBS Hospice Care
- ❑ HCBS Personal Care
- ❑ Hearing Impaired
- ❑ Home Care Agency
- ❑ Home Health Agency
- ❑ Home Infusion Therapy
- ❑ Homemaker
- ❑ Meals on Wheels
- ❑ Occupational Therapy
- ❑ PACE Program
- ❑ Physical Therapy
- ❑ Rehabilitation
- ❑ Respiratory Care
- ❑ Senior Center
- ❑ Transportation Program
- ❑ Other_________________

LeadingAge Illinois' bylaws require:

- That all levels of care within a single organization be included in LeadingAge Illinois membership – (e.g. a community that has both assisted living and independent living units must include all units in their LeadingAge Illinois membership).
- That each Illinois organization affiliated with a multi-site corporation/system must be in LeadingAge Illinois membership – (e.g. a multi-site corporate housing sponsor must bring each of its sites into LeadingAge Illinois membership.

MEMBERSHIP DUES CALCULATIONS *(Actual dues will be calculated by LeadingAge Illinois and invoiced accordingly)*

LeadingAge Illinois calculates dues using a millage system based on program service revenue. Please note that the information you provide is for LeadingAge Illinois internal staff use only, to determine your membership dues. It will not be shared with any other organization.

1. If your organization *does not* file a Form 990 with the IRS, provide program service revenue from one of the following documents:
   - ❑ The Organization's most recent Audited Financial Statement
   - ❑ Medicaid Cost Report
   - ❑ Profit and Loss statement
   - ❑ Rental Income (Housing members only)

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

____ ____

Program Service Revenue Fiscal Year

Invoice Contact Name/Title: ____

Address: ____

Phone: ____________________________ Email: ____

LeadingAge Illinois Dues Millage System:

Program Service Revenue=	>$10M	$1M-$10M	<$1M
Rate x PSR	0.00065	0.00070	0.00075
Plus	$750	$250	$100

Maximum Dues: $24,000 Minimum Dues: $500