HOUSING /ASSISTED LIVING MEMBERSHIP APPLICATION

*Today's Date:*_____

GENERAL INFORMATION

Please print or type all information

Name of Facility _____

Address _____

City _____ State _____ Zip Code _____

Phone ( ) _____ Fax ( )_____

E-Mail _____ Web Site_____

Facility Contact: _____ Title _____

Corporate Sponsor _____

Address _____

Corporate Contact _____ Phone( )_____

QUESTIONS?

Call – (317)733-2380

Mail this form to:

LeadingAge Indiana,
P.O. Box 68829
Indianapolis, IN
46268-0829

Or fax to:

(317) 733-2385

UNLICENSED CAPACITY

Please list the number of unlicensed units in the following categories:

_____ Assisted Living

_____ Unlicensed Residential Care

_____ Independent Apartments/Congregate living

_____ Federally Subsidized Apartments

_____ Cottages

_____ Duplexes (list total number of units available)

_____ Other (please describe)_____

COMMUNITY BASED SERVICES

Please indicate if you provide these additional community based services.

_____ Adult Day Care / Number of clients served? _____

_____ Home Health Care ____Child Day Care _____ Congregate Meal Site

_____ Respite Care ____ Meals on Wheels ____ Outpatient Therapies

_____ Hospice ____ Transportation _____ Homemaker Services

_____ Other Services (please describe) _____

ABOUT YOUR STAFF

Please include names / E-mail Address

Administrator/Manager (circle one)_____ _____

Activities Director_____ _____

Service Coordinator / Social Worker_____ _____

Food Service_____ _____

Housekeeping_____ _____

Maintenance_____ _____

Human Resources_____ _____

Business Office_____ _____

Marketing/Admissions_____ _____

Resident Services_____ _____

INDIANA STATE LEGISLATURE INFORMATION

Legislative Districts of the facility: House # _____ Senate # _____

If not known, names of Indiana State Senator and Representative:

State Senator _____ State Representative _____ _

Are you personally well acquainted with any state representative/senator? _____ __

If so, who? _____ (May or may not be in your district)

Describe your relationship_____